



HRT Cream Order Form

Patient Name: _____ Date of Birth: _____ Rx Date: _____ Phone: _____ ID/License: _____
Physical Address: _____ City: _____ State: _____ Zip: _____

Please compound the following medication for Hormone Replacement Therapy:

Medication	Quantity 30g Each	Instructions		Refills
<u>Testosterone 200mg/g Cream</u> <u>(For Men)</u>		☐ 1 Click (0.25g) (50mg of Testosterone) ☐ 2 Clicks (0.50g) (100mg of Testosterone)	☐ 3 Clicks (0.75g) (150mg of Testosterone) ☐ 4 Clicks (1.0g) (200mg of Testosterone)	NR – 1 – 2 – 3 – 4 – 5
<u>Testosterone 4mg/g Cream</u> <u>(For Women)</u>		☐ 1 Click (0.25g) (1mg of Testosterone) ☐ 2 Clicks (0.50g) (2mg of Testosterone)	☐ 3 Clicks (0.75g) (3mg of Testosterone) ☐ 4 Clicks (1.0g) (4mg of Testosterone)	NR – 1 – 2 – 3 – 4 – 5
<u>Testosterone 10mg/g Cream</u> <u>(For Women)</u>		☐ 1 Click (0.25g) (2.5mg of Testosterone) ☐ 2 Clicks (0.50g) (5mg of Testosterone)	☐ 3 Clicks (0.75g) (7.5mg of Testosterone) ☐ 4 Clicks (1.0g) (10mg of Testosterone)	NR – 1 – 2 – 3 – 4 – 5
<u>BiEst 50/50* 2mg/g</u> <u>(For Women)</u>		☐ 1 Click (0.25g) (0.5mg of BiEst) ☐ 2 Clicks (0.50g) (1mg of BiEst)	☐ 3 Clicks (0.75g) (1.5mg of BiEst) ☐ 4 Clicks (1.0g) (2mg of BiEst)	NR – 1 – 2 – 3 – 4 – 5
<u>BiEst 50/50* 4mg/g</u> <u>(For Women)</u>		☐ 1 Click (0.25g) (1mg of BiEst) ☐ 2 Clicks (0.50g) (2mg of BiEst)	☐ 3 Clicks (0.75g) (3mg of BiEst) ☐ 4 Clicks (1.0g) (4mg of BiEst)	NR – 1 – 2 – 3 – 4 – 5
<u>BiEst 70/30* 2mg/g</u> <u>(For Women)</u>		☐ 1 Click (0.25g) (0.5mg of BiEst) ☐ 2 Clicks (0.50g) (1mg of BiEst)	☐ 3 Clicks (0.75g) (1.5mg of BiEst) ☐ 4 Clicks (1.0g) (2mg of BiEst)	NR – 1 – 2 – 3 – 4 – 5
<u>BiEst 70/30* 4mg/g</u> <u>(For Women)</u>		☐ 1 Click (0.25g) (1mg of BiEst) ☐ 2 Clicks (0.50g) (2mg of BiEst)	☐ 3 Clicks (0.75g) (3mg of BiEst) ☐ 4 Clicks (1.0g) (4mg of BiEst)	NR – 1 – 2 – 3 – 4 – 5
<i>*BiEst consists of Estriol and Estradiol. BiEst 50/50 contains 0.5mg of Estriol and 0.5mg of Estradiol per mg of BiEst. BiEst 70/30 contains 0.7mg of Estriol and 0.3mg of Estradiol per mg of BiEst.</i>				

Sig. Apply to skin rotating between the inner arm and lower extremities once daily.

Signature: _____ Dr. Name (Print): _____

License #: _____ NPI #: _____ DEA #: _____ DM: _____ Phone Number: _____

DEA Address: _____ City: _____ State: _____ Zip: _____

Disclaimer: By signing this form, the prescriber understands that the above products are compounded medications and are not approved by the FDA, however, these products shall be prepared by a pharmacy in accordance with state and federal regulations with an order by a licensed prescriber and are only available by prescription. This should be treated as a HIPAA protected document. Any disclosure, copying, distribution or unauthorized use of this information is strictly prohibited.

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