

 Fax

To: Park Compounding

From: \_\_\_\_\_

Fax: 949-551-1950

Phone: 858-704-4045

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

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PROTECTED HEALTH INFORMATION

BUSINESS CONFIDENTIAL INFORMATION

**This fax is intended only for the exclusive use of the addressee(s), and may contain privileged or confidential information. If you are not the intended recipient, or the person responsible for delivering the fax to the intended recipient, be advised you have received this fax in error and that use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please destroy the attached document(s) and immediately notify the sender of the error.**

Please deliver to: \_\_\_\_\_ with this cover sheet to protect its contents.

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      Earliest Date To Be Administered: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

**Physician Information** Required

Prescribing Physician: \_\_\_\_\_

DEA: \_\_\_\_\_ NPI#: \_\_\_\_\_

Center/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Primary Contact: \_\_\_\_\_

Email: \_\_\_\_\_

**\*If multiple prescribing physicians, use separate order form for each.**

**Patient Information** Required

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Known Drug Allergies: \_\_\_\_\_

No Known Drug Allergies (NKDA)

Patient Profile(s) or Block Schedule Attached:    YES    NO (circle one)

# of Patients\*: \_\_\_\_\_

Paid by:  Physician/Clinic     Patient

Ship to:  Physician/Clinic     Patient

If you need a medication not listed, please contact us at 858-704-4644

Medication	Strength or Concentration	Size/Volume	Instructions for use	Catheter	Quantity
<input type="checkbox"/> <b>Hep-Lido-A**</b> (alkalinized lidocaine, heparin)	Heparin 66,000u/Lido HCl 265mg per syringe** <i>alternate</i> _____	20ml single-use syringe kit	Instill into the bladder through a catheter per physician instructions given at office visit	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Pediatric	_____ syringe(s) <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly
	Directions: _____				# Refills
<input type="checkbox"/> <b>Elmiron®</b> (pentosan polysulfate sodium)	<b>Elmiron® 100mg capsule</b>	90 capsules	1 capsule by mouth 3 times a day	n/a	Quantity    # Refills
<input type="checkbox"/> <b>PPS-DR**</b> (pentosan polysulfate sodium delayed release)	<b>150mg delayed release capsule**</b> <i>alternate</i> _____	60 capsules	1 capsule by mouth 2 times a day or as instructed at your doctor visit	n/a	Quantity    # Refills

\*Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice.  
 \*\*Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss.

**REMINDER: Please check patient information has been included for all medications before submitting.**

**Order Submission**

THIS FORM CONSTITUTES A PHYSICIAN'S ORDER/PRESCRIPTION WHEN SIGNED BY THE PHYSICIAN

Please FAX with cover sheet to Park Compounding      Authorized Physician's Signature  
**949-551-1950**      X \_\_\_\_\_

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

# of Prescriptions \_\_\_\_\_

**Payment Information**

IF NO CREDIT CARD ON FILE AND YOU ARE NOT CURRENTLY BEING INVOICED, PLEASE SUBMIT THE FOLLOWING:

Credit Card Number: \_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_ CVC Code: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

This form is provided in an effort to improve patient safety.

Current as of 10/7/15 v5



# Patient Reimbursement Requirements

## Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

If you have questions, please contact us at **858-704-4644**

## Diagnosis

ICD-10 Code

**N30.10**

**Other** \_\_\_\_\_

## Treatments

Tried and Failed Treatments

**Elmiron®**

**Traditional Bladder Medications**

**Other** \_\_\_\_\_

Reason(s) treatment(s) failed

**Allergic Reaction**

**Ineffective**

**Other** \_\_\_\_\_

**Clinical notes for patient identified above are attached.**

**Patient Information**

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic		Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic		Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic		Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic		Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
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				NKDA <input type="checkbox"/>
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First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic		Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA <input type="checkbox"/>
<input type="checkbox"/> Ship to Patient <input type="checkbox"/> Ship to Clinic		Number of Refills:	Paid by: <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Patient	

Unless otherwise indicated above, all patients identified with this order do not have allergies to any of the ingredients within the Hep-Lido-A compounded formulation.