



U Save It Pharmacy - Peach Valley
 2310 Chesnee Hwy,
 Spartanburg, SC 29303
 P: 864-577-0087 F:864-577-0599

Patient Name: _____ DOB: _____ Phone #: _____

Address: _____ City/State/Zip: _____

COMPOUNDED MEDICATION	STRENGTH	DISPENSE	DIRECTIONS	REFILLS
<u>Lip Balm: Herpes Symplex</u> Acyclovir / Deoxy-D-Glucose (2) – Plasticized Base	<input type="checkbox"/> 2% / 2%	<input type="checkbox"/> 15gm Tube	Apply a small amount to affected area(s) twice a day	
<u>Shingles: Herpes Zoster</u> Acyclovir / Deoxy-D-Glucose (2) / Gabapentin / Ketoprofen / Amitriptyline / Tetracaine / Lidocaine (Lipoderm Cream Base)	<input type="checkbox"/> 5%/0.2%/5%/5%/2%/1%/3%	<input type="checkbox"/> 30ml pump	Apply a small amount to affected area(s) up to three times a day	
<u>Shingles - Residual: Herpes Zoster Psoriasis, Autoimmune Skin Disorders</u> Naltrexone – U Cream	<input type="checkbox"/> 1%	<input type="checkbox"/> 30ml pump	Apply a small amount to affected area(s) up to three times a day	
<u>Mouth Wash:</u> Diphenhydramine/Tetracycline/ Hydrocortisone/ Nystatin (MW-Diph/TCN/HC/Nyst)	<input type="checkbox"/> 180ml/1.5gm/60mg/60ml (0.1125/0.375/0.015%/15000U/ml)	<input type="checkbox"/> 400 ml <input type="checkbox"/> _____	Swish and spit 1 tablespoon (15mls) by mouth every 4-6 hours prn	
<u>Autoimmune Disorders Titration:</u> Naltrexone HCl Capsules (Low Dose Naltrexone)	<input type="checkbox"/> 1.5 mg	<input type="checkbox"/> #90 caps (6 weeks supply)	1 cap PO QHS x14 days, then 2 caps QHS x14 days, then 3 caps QHS. Then switch to 4.5mg capsules.	
<u>Autoimmune Disorders Maintenance:</u> Naltrexone HCl Capsules (Low Dose Naltrexone)	<input type="checkbox"/> 4.5 mg	<input type="checkbox"/> #30 caps <input type="checkbox"/> #60 caps <input type="checkbox"/> #90 caps	<input type="checkbox"/> 1 cap PO QHS <input type="checkbox"/> 1 cap PO QAM	

Doctor Name (Printed): _____ DEA: _____ Phone: _____

Dispense as Written

Substitution Permitted