TOWN & COUNTRY
compounding | consultation

ACCREDITED
Compounding Pharmacy

BIODENTICAL HORMONE MGMT.
ACHC Accredited Pharmacy
Phone: 201-447-2020
Fax: 201-447-3253
Pharmacist@TCcompound.com

Patient's Name:	Prescriber's Name:
Street Address:	Street Address:
City, State ZIP:	City, State ZIP:
Date of Birth:	Office #:
Phone (CELL) #:	Fax #:
Email:	Email:
Patient Allergies:	

PRESCRIBER'S SIGNATURE: X ________________________________ **DATE:** ____________

Commonly Requested Compounds for Bioidentical Hormone Replacement Therapy

1. ________ **Bi-Est 50:50 (50% Estradiol - 50% Estriol) Cream (* 180-Day Exp.)**
   SIG: ( ) 0.25mg ( ) 0.5mg ( ) 0.75mg ( ) 1mg — **Frequency:** ____________

2. ________ **Bi-Est 80:20 (20% Estradiol – 80% Estriol) Cream (30-Day ONLY Exp.)**
   SIG: ( )_______mg — **Frequency:** ____________

3. ________ **Progesterone Cream**
   SIG: ( ) 25mg ( ) 50mg ( ) 75mg ( ) 100mg — **Frequency:** ____________

4. ________ **Progesterone Slow Release Capsule**
   SIG: ( ) 50mg Capsule ( ) 100mg Capsule ( ) 200mg Capsule — **Frequency:** ____________

5. ________ **Progesterone Suppository** — **Frequency:** ____________
   SIG: ( ) 100 mg **SIG:** ( ) 200 mg

6. ________ **Testosterone Cream** — **Frequency:** ____________
   SIG: ( ) 0.5mg ( ) 1mg ( ) 2mg ( ) 3mg

Vaginal:

7. ________ **Estriol 0.05% Vaginal Cream in Mucolox™ / Versabase™** — **Frequency:** ____________
   SIG: ( ) Insert 1 gm vaginally HS for 14 nights then 2-3 times a week as needed.

Non-Hormonal: — **Frequency:** ____________

8. ________ **Hyaluronic Acid 5mg/gm Vaginal Gel in Mucolox™ / Versabase™**
   SIG: ( ) Insert 1 gm vaginally HS for 14 nights then 2-3 times a week as needed.

Directions: ____

Day Supply: ____

Refills: (# of refill refers to all medications prescribed above) ____ 5 ____ 4 ____ 3 ____ 2 ____ 1

*** Stability tested for 180-day expiration, patient savings for 60 and 90-day supply.**

As always, the FDA does not evaluate compounded medications for safety or efficacy.