TOWN & COUNTRY
compounding | consultation

ACCREDITED
Compounding Pharmacy

Bi/Tri/Quad Mix Order Form
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 Erectile Dysfunction Therapy

1. _____ **Bi-Mix 1 (Papaverine 30mg/ml – Phentolamine 0.5mg/ml) Injection**

   SIG: _____ **Volume:** _____

2. _____ **Bi-Mix 2 (Papaverine 30mg/ml – Phentolamine 1mg/ml) Injection**

   SIG: _____ **Volume:** _____

3. _____ **Tri-Mix 1 (Papaverine 30mg/ml – Phentolamine 1mg/ml – Prostaglandin 10mcg/ml) Injection**

   SIG: _____ **Volume:** _____

4. _____ **Tri-Mix 2 (Papaverine 30mg/ml – Phentolamine 1mg/ml – Prostaglandin 20mcg/ml) Injection**

   SIG: _____ **Volume:** _____

5. _____ **Tri-Mix 3 (Papaverine 30mg/ml – Phentolamine 1mg/ml – Prostaglandin 30mcg/ml) Injection**

   SIG: _____ **Volume:**_____

6. _____ **Tri-Mix 4 (Papaverine 30mg/ml – Phentolamine 1mg/ml – Prostaglandin 40mcg/ml) Injection**

   SIG: _____ **Volume:**_____

7. _____ **Super Tri-Mix (Papaverine 30mg/ml – Phentolamine 2mg/ml – Prostaglandin 40mcg/ml) Injection**

   SIG: _____ **Volume:**_____

8. _____ **Quad-Mix (Add Atropine _____mg/ml to Tri-Mix #_____)**

   SIG: _____ **Volume:**_____

9. _____ **Syringes** _____ **Gauges** _____ **Inch**

Refills: (Number of refills indicated here refers to all medications prescribed above)

_____ **5** _____**4** _____**3** _____**2** _____**1**