Northwest Compounders
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Compounded Bioidentical Hormone Replacement: E2, E3 and E2-E3 Creams Rx Template

Patient's Name:_____ DOB:_____

Patient's Address:_____ City:_____ State_____, Zip:_____

Patient's Phone:_____ **Drug Allergies:**_____

Formulation Selection (choose by checking the box to the left of the formula)

Estradiol (E2) Topical/Vaginal Cream

☐ Estradiol (E2) Topical/Vaginal Cream

☐ 0.1mg/gm ☐ 0.11mg/gm ☐ 0.15mg/gm ☐ 0.2mg/gm ☐ 0.5mg/gm

☐ 1mg/gm ☐ 2mg/gm ☐ 4mg/gm ☐ ___mg/gm

***Prescribers: If you are prescribing compounded estradiol topical/vaginal cream, please provide a medical rationale that states why Estrace© is not an appropriate treatment option for this patient:

_____

_____

i.e. "patient is allergic to inactive ingredients in Estrace©" note-> Cost is not considered a valid rationale

Estriol (E3) Topical/Vaginal Cream

☐ Estriol (E3) Topical/Vaginal Cream ☐ 1mg/gm ☐ 2mg/gm ☐ ___mg/gm

Estradiol (E2) + Estriol (E3) Topical or Vaginal Cream

☐ E2-E3 20:80 Cream ☐ 0.25mg/gm ☐ 1mg/gm ☐ 2mg/gm ☐ ___mg/gm

☐ E2-E3 50:50 Cream ☐ 0.25mg/gm ☐ 1mg/gm ☐ 2mg/gm ☐ ___mg/gm

☐ E2-E3 ___:___ Cream (enter ratio) ☐ 0.25mg/gm ☐ 1mg/gm ☐ 2mg/gm ☐ ___mg/gm

Quantity: 30gm—-60gm—-90gm—-120gm— #_____gm (please circle or write in)

***All hormone creams dispensed in metered dosing pump

Refills: 0—1—2—3—4—5—PRN—#_____ (please circle or write in)

Directions for Use:

_____

_____

_____

Prescriber's Name:_____ Date:_____

Prescriber's Street Address:_____ City:_____ State:_____ Zip:_____

Prescriber's Phone Number:_____ Name of person submitting order:_____

Fax completed forms to (503)-624-0591 or email them to info@northwestcompounders.com