



Compounded Formulas for Vaginal Atrophy or Dryness 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) 0.1mg/gm-2mg/gm Topical/Vaginal Cream (write-in strength)

***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

☐ Estradiol (E2)-Estrinol (E3) 50:50 1mg/gm Vaginal Cream

☐ Estradiol (E2)-Estrinol (E3) 50:50 1mg/gm Vaginal Gel

☐ Estriol (E3) 0.025% to 1% Topical/Vaginal Cream (write-in desired strength)

☐ Estriol (E3) 0.05% Vaginal Gel

☐ Estriol (E3) 1mg Vaginal Suppository

☐ Estriol (E3) 0.1%-Progesterone 3% Vaginal Gel

☐ Estriol (E3) 1mg-Progesterone 30mg Vaginal Suppository

Quantity Selection (choose a dispense quantity by checking the corresponding box)

☐ 30 each ☐ 60 each ☐ 90 each ☐ each

Directions for Use (Choose pre-worded directions below or manually enter directions for use)

☐ Use applicator to insert 1mL vaginally TIW QHS

☐

Refills?

☐ Refill time(s)

☐ No Refills

Prescriber's Name: Date:

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

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