Andrews Apothecary

3072-A Trenwest Drive, Winston Salem, NC 27103
phone 336-723-1679 Please Fax to: 336-723-1670

Patient name:_____ Date of Birth:_____

Best phone number:_____ Email:_____

Street address:_____ City:_____State:_____ Zip:_____

Allergies:_____ **Form 1 of 2 for GAP**

****Please circle desired formula number and circle or enter the desired quantity. No medical claims intended.****

1	**Budesonide 5mg DR Caps #60 or _____**	**Sig: 2 caps (10mg) po once daily**
2	**Nifedipine 0.2% Cream Disp: 30gm or 60gm ***circle one*****	**Sig: Apply pea sized amount to anus TID**
3	**Nifedipine 0.2%+Hydrocortisone 1% Oint Disp: 30gm or 60gm ***circle one*****	**Sig: Apply pea sized amount to anus TID**
4	**Nifedipine 0.2%+Lidocaine 5% Oint Disp: 30gm or 60gm ***circle one*****	**Sig: Apply pea sized amount to anus TID**
5	**Lidocaine 5%+Hydrocortisone 2.5% Cream Disp: 30gm or 60gm ***circle one*****	**Sig: Apply pea sized amount to anus TID**
6	**Rectal Rockets=Hydrocortisone 2% +Lidocaine 2%--dispense #5 or _____**	**Sig: Insert one rocket suppository PR qhs**
7	**Hydrocortisone 20mg Suppositories Dispense: #_____**	**Sig: Insert one suppository PR BID x _____days**
8	**Budesonide 0.25mg/ml methocel suspension Disp: 240ml or _____**	**Sig: Take 4ml po BID. After swallowing, rinse mouth and spit out. No food or drink for 30 minutes**

Additional comments or formulations:

_____

Refills (circle one): 0 1 2 3 4 5 6 PRN

Prescriber name printed here please_____ Signature here:_____
Today's date:_____

THIS FORM PROVIDED AT THE REQUEST OF THE PRESCRIBER

Please email us at refills@andrewsapothecary.com with your practice info as you would like for it to appear and we will gladly make the edit for you and email back a clean copy. Please attach the fax form that you want so that we can be sure to get you what you need.