GEM Rx
Edwards Pharmacy™

VETERINARY COMPOUNDED PRESCRIPTION REQUEST FORM
Please fax to 844-705-0156
Questions? Call us at 866-552-5522

Patient Information:

Pet Name:_____

Owner's Name:_____

DOB: __ /__ /_____ Species: _____

Phone Number: (___) ___-_____

Address: _____

City: _____ State: ___ Zip: _____

Clinic Name: _____

Doctor's Name: _____

Person Faxing Form: _____

DEA: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: (___) _____-_____ Fax: (___) _____-_____

PRESCRIPTION
ONLY ONE SELECTION PER FORM

Drug: ☐ Methimazole Transdermal Cream **Strength:** ☐ 2.5mg/click ☐ 5mg/click ☐ 7.5mg/click ☐ 10mg/click	**SIG:**	**Quantity:** ☐ 30 Days ☐ 90 Days ☐ 60 Days ☐ Other: _____
Drug: ☐ Prednisolone Oral Suspension **Strength:** ☐ 2.5mg/mL ☐ 5mg/mL ☐ 7.5mg/mL ☐ 10mg/mL ☐ 15mg/mL ☐ 20mg/mL	**SIG:**	**Quantity:** ☐ 30 Days ☐ 90 Days ☐ 60 Days ☐ Other: _____
Drug: ☐ Metronidazole Benzoate Suspension **Strength:** ☐ 50mg/mL ☐ 100mg/mL ☐ 125mg/mL	**SIG:**	**Quantity:** ☐ 30 Days ☐ 90 Days ☐ 60 Days ☐ Other: _____
Drug: _____ **Strength:** _____	**SIG:**	**Quantity:** ☐ 30 Days ☐ 90 Days ☐ 60 Days ☐ Other: _____
Drug: _____ **Strength:** _____	**SIG:**	**Quantity:** ☐ 30 Days ☐ 90 Days ☐ 60 Days ☐ Other: _____

BILLING/SHIPPING INFORMATION

☐ Bill Patient / Ship Patient
☐ Bill Clinic / Ship Patient
☐ Bill Clinic / Ship Clinic
☐ URGENT: add $8.00 shipping fee for expedited shipping.

REFILLS (PLEASE SELECT)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Other_____

NOTE TO PRESCRIBER: If you have a patient with special needs, please call us at (866) 552-5522 for additional options.

Doctor's Signature: _____ **Date:** _____

Prescribers are reminded patients may choose any pharmacy of their choice.