



Completed patient prescriptions can be submitted by:

- Log into your online account at www.mcguffpharmacy.com
- Calling 877-444-1133
- Emailing: pharmacyanswers@mcguff.com
- Faxing 877-444-1155



Please ensure all required fields are completed. Missing information will delay your prescription.

The drugs on this prescription are compounded unless the commercial product is available. These compounded drugs are medically necessary for this patient.
 ALL FIELDS REQUIRED. Missing information will delay your order.

Patient: _____ Rx Date: ___/___/___
 DOB: ___/___/___ M F Tel: _____
 Address: _____

 Allergies: _____
 Medications: _____
 Medical Conditions: _____

Prescriber: _____
 Address: _____

 Tel: _____ Fax: _____
 Lic#: _____
 Email: _____

SDV: Single Dose Vial – Intended for one time use. Discard 1 hour after 1st use or puncture.

MDV: Multi-dose Vial – Contains preservative. Discard 28 days after 1st use or puncture.

Qty	Compounded Preparation	Directions (CIRCLE route of administration, fill in dose and frequency)
	Arginine HCL 100 mg/mL 10 mL SDV	Administer IV _____ mL _____ time(s) every _____.
	Biotin 10 mg/mL 10 mL SDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Dexpanthenol 250 mg/mL 10 mL SDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Dexpanthenol 250 mg/mL 30 mL MDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Edetate Disodium (EDTA) 150 mg/mL 20 mL SDV	Administer IV _____ mL _____ time(s) every _____.
	Edetate Calcium Disodium 300 mg/mL 10 mL SDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Glycerin 72% 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Glycine 50 mg/mL 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Hydrochloric Acid 1:500 (2 mg/mL) 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Hydrocortisone 0.2 mg/mL 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Hydroxocobalamin 5 mg/mL 2 mL SDV*	Administer IM _____ mL _____ time(s) every _____.
	Hydroxocobalamin 5 mg/mL 10 mL MDV*	Administer IM _____ mL _____ time(s) every _____.
	Hydroxocobalamin 5 mg/mL 30 mL MDV*	Administer IM _____ mL _____ time(s) every _____.
	Lysine HCL 100 mg/mL 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Niacinamide 100 mg/mL 30 mL MDV	Administer IV / IM _____ mL _____ time(s) every _____.

* **Hydroxocobalamin 1 mg/mL 30mL MDV is available commercially.** Medical justification is required to dispense the compounded Hydroxocobalamin 5mg/mL preparation for your patient. Please list the medical justification: _____.

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Patient: _____

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MDV: Multi-dose Vial – Contains preservative. Discard 28 days after 1st use or puncture.

Qty	Compounded Preparation	Directions (CIRCLE route of administration, fill in dose and frequency)
	Procaine HCL 20 mg/mL (2%) 10 mL SDV	Administer SQ / IM _____ mL _____ time(s) every _____.
	Procaine HCL 20 mg/mL (2%) 30 mL MDV	Administer SQ / IM _____ mL _____ time(s) every _____.
	Proline 50 mg/mL 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Pyridoxine HCL 100 mg/mL + Riboflavin 1 mg/mL 2 mL SDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Pyridoxine HCL 100 mg/mL + Riboflavin 1 mg/mL 30 mL MDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Riboflavin-5'-Phosphate Sodium 50 mg/mL 30 mL MDV	Administer IV / IM _____ mL _____ time(s) every _____.
	Taurine 100 mg/mL 30 mL MDV	Administer IV _____ mL _____ time(s) every _____.
	Taurine 100 mg/mL 30 mL SDV	Administer IV _____ mL _____ time(s) every _____.
	Vitamin D3 Water Miscible IM 10,000 IU/mL 30 mL MDV	Administer IM _____ mL _____ time(s) every _____.

REFILL(S): _____

Bill To: Doctor Patient

Ship To: Doctor Patient

Payment Information	
CC Number: _____	Exp: _____ Code: _____
Name on card: _____	Billing Zip: _____
<input type="checkbox"/> Card on file ending in: _____	

X _____ Prescriber's signature.
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