

Anti-Infective Drugs

DOCTOR NAME, OD
 Street Address, City, State Zip
 Phone: # Fax: #

DEA: 00000000

Date: _____

DOB: _____

Rx

Dispense ONE Marked Below

- | | | |
|---|---|---|
| <input type="checkbox"/> Augmentin 250mg 500mg po | <input type="checkbox"/> Keflex 250mg 500mg po | <input type="checkbox"/> Tobrex 0.3% gtt(s) ung |
| <input type="checkbox"/> Bacitracin ung | <input type="checkbox"/> Maxitrol ung | <input type="checkbox"/> Vigamox 0.5% gtt(s) |
| <input type="checkbox"/> Ciloxan 0.3% gtt(s) ung | <input type="checkbox"/> Ofloxacin 0.3% | <input type="checkbox"/> Viroptic 1% |
| <input type="checkbox"/> Cipro 100mg 250mg 500mg po | <input type="checkbox"/> Poltrim 0.1% gtt(s) | <input type="checkbox"/> Zithromax (Z pac) 250mg po |
| <input type="checkbox"/> Doxycycline 100 mg po | <input type="checkbox"/> Quixin 0.5% gtt(s) | <input type="checkbox"/> Zovirax 200mg 400mg 800mg po |
| <input type="checkbox"/> Erythromycin 0.5% ung 250mg po | <input type="checkbox"/> Tetracycline 250mg po | <input type="checkbox"/> Zymar 0.3% gtt(s) |
| <input type="checkbox"/> Gentamicin 0.3% gtt(s) ung | <input type="checkbox"/> Tobradex 0.3% gtt(s) ung | <input type="checkbox"/> |

Sig: _____ Tab(s) Cap(s) gtt(s) q _____ X _____ Days

OD OS OU po bid tid qid prn ac pc hs shake well

5 ml 10 ml 15 ml Refill: None _____ Times

Dr. _____

Dr. _____

Dispense as Written

Substitution Permitted

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Anti-Inflammatory & Anti-Allergy Drugs

DOCTOR NAME, OD
 Street Address, City, State Zip
 Phone: # Fax: #

DEA: 00000000

Date: _____

DOB: _____

Rx

Dispense ONE Marked Below

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acular 0.5% PF | <input type="checkbox"/> Clarinex 5mg | <input type="checkbox"/> Livostin 0.05% | <input type="checkbox"/> Pred Mild 0.125% |
| <input type="checkbox"/> Acular LS 0.4% | <input type="checkbox"/> Zmadine 0.05% | <input type="checkbox"/> Lotemax 0.5% | <input type="checkbox"/> Vexol 1% |
| <input type="checkbox"/> Alamast 0.1% | <input type="checkbox"/> Flarex 0.1% | <input type="checkbox"/> Opticrom 4% | <input type="checkbox"/> Voltaren 0.1% |
| <input type="checkbox"/> Allegra 60 mg | <input type="checkbox"/> FML 0.1% gtt(s) | <input type="checkbox"/> Optivar 0.05% | <input type="checkbox"/> Zaditor 0.025% |
| <input type="checkbox"/> Alocril 2% | <input type="checkbox"/> FML Forte 0.25% gtt(s) | <input type="checkbox"/> Patanol 0.1% 0.2% | <input type="checkbox"/> Zyrtec 5mg |
| <input type="checkbox"/> Alomide 0.1% | <input type="checkbox"/> Inflamase Forte 1% | <input type="checkbox"/> Pred Forte 1% | |
| <input type="checkbox"/> Alrex 0.2% | <input type="checkbox"/> Inflamase Mild 0.125% | <input type="checkbox"/> | |

Sig: _____ Tab(s) Cap(s) gtt(s) q _____ X _____ Days

OD OS OU po bid tid qid prn ac pc hs shake well

5 ml 10 ml 15 ml Refill: None _____ Times

Dr. _____

Dr. _____

Dispense as Written

Substitution Permitted

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No Drugs Listed

DOCTOR NAME, OD
Street Address, City, State Zip
Phone: # Fax: #

DEA: 00000000

Date: _____

DOB: _____

Rx

Sig: _____ Tab(s) Cap(s) gtt(s) q _____ X _____ Days

OD OS OU po bid tid qid prn ac pc hs shake well

5 ml 10 ml 15 ml Refill: None _____ Times

Dr. _____ Dr. _____

Dispense as Written

Substitution Permitted

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Glaucoma Drugs

DOCTOR NAME, OD
Street Address, City, State Zip
Phone: # Fax: #

DEA: 00000000

Date: _____

DOB: _____

Rx

Dispense ONE Marked Below

Alphagan-P 0.15%

Lumigan 0.03%

Timoptic 0.25% 0.5%

Azopt 1%

Ocupress 1%

Timoptic XE 0.25% 0.5%

Betagan 0.25% 0.5%

OpiPranolol 0.3%

Travatan 0.004%

Betimol 0.25% 0.5%

Pilocarpine 1% 2% 4%

Trusopt 2%

Betoptic 0.5%

Propine 0.1%

Xalatan 0.005%

Cosopt

Rescula 0.15%

Sig: _____ Tab(s) Cap(s) gtt(s) q _____ X _____ Days

OD OS OU po bid tid qid prn ac pc hs shake well

5 ml 10 ml 15 ml Refill: None _____ Times

Dr. _____ Dr. _____

Dispense as Written

Substitution Permitted

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