Provider Name : _____

Address : _____

Phone # : _____

DEA #: _____

NPI # : _____

NAME_____ DOB _____

ADDRESS_____

Rx

Compound

Hydroquinon 8%

+Tretinoin 0.025%

+Hydrocortison 2.5%

+Vit C 0.5%

#30gm

REFILL_____ TIMES

DO NOT SUBSTITUTE ☐ _____

signature _____

Date _____