

THIS FORM IS FOR INFORMATIONAL PURPOSES ONLY
 ALL PRESCRIPTIONS WILL NEED AN INDIVIDUAL PRESCRIPTION
 WATKINS COMPOUNDING PHARMACY IS A 503A PHARMACY

FORTIFIED OPHTHALMICS

VANCOMYCIN OPHTHALMIC DROPS	15 ML
<u>25MG/ML</u> <u>33MG/ML</u> <u>50MG/ML</u>	
TOBRAMYCIN OPHTHALMIC DROPS	14 ML
<u>13.6MG/ML</u>	
CEFAZOLIN OPHTHALMIC DROPS	15ML
<u>25MG/ML</u> <u>50MG/ML</u>	
GENTAMYCIN OPHTHALMIC DROPS	14 ML
<u>13.6MG/ML</u>	

SINGLE USE PREFILLED SYRINGES

CYCLOCAINE PRE-OP SYRINGES	0.6 ML
LIDOCAINE 2%/CYCLOPENTOLATE 1%/PHENYLEPHRINE 10% MOXIFLOXACIN 0.5%/BSS SOLN	
CAT GEL PRE-OP SYRINGES	0.6ML
LIDOCAINE 2%/CYCLOPENTOLATE 1%/PHENYLEPHRINE 10% MOXIFLOXACIN 0.5%/KETOROLAC 0.5%	
VERDIER CAT GEL PRE-OP SYRINGES	0.6ML
LIDOCAINE 2%/PHENYLEPHRINE 10%/CYCLOPENTOLATE 1% OFLOXACIN 0.3%/KETOROLAC 0.5%	
MOXIFLOXACIN / BSS 1MG/ML	0.35ML

SPECIALTY DROPS

FLUOROURACIL 1% DROPS	10ML
ACETYLCYSTEINE 2% OR 10% DROPS	15 ML
LOSARTAN (PF) 0.8mg/ml DROPS	24 ML
EDTA 2% OR 3% DROPS	5ML

***SERUM TEARS DROPS 33% OR 50%**

***THIS REQUIRES LABORATORY COORDINATION**

GIVE US A CALL TODAY

DIRECT (231) 683-1708

FAX: 231-737-1329

FOR FAX TRANSMITTAL TO WATKINS PHARMACY 231-737-1329
EMAIL: WATKINSPHARMACY@WATKINSPHARMACY.COM

WATKINS
PHARMACY
1391 E SHERMAN BLVD
MUSKEGON, MI 49444
(231) 739-7158



NAME: _____ DOB: _____
ADDRESS: _____ CITY: _____ ZIP: _____
PHONE: ____ (____) _____ ALLERGIES: _____

All compounds will require a written prescription for each *individual* patient.

DATE: _____

MEDICATION: _____

QTY: _____ REFILLS: _____

Sig: _____

Physician Name (Print): _____

Physician Signature: _____

DEA # _____ Office Phone #: _____ DATE: _____

CUSTOM FORMULAS WELCOME

LAB DIRECT: 231-683-1708

FAX: 231-737-1329

THIS FORM IS ONLY TO BE USED BY A LICENSED HEALTH PROFESSIONAL

PRESCRIPTIONS WILL BE VERIFIED BY THE OFFICE