OP DROPS™

Hunt Valley PharmaLAB

NovoTears™ — We Make Eye Drops Personal™

STAT DROPS™

Prescribing Sheet

Dr. ____________________

Address:

____

____

Phone: ____________________

Email To: RX@HVPCC.COM

Fax To: 410-666-7253

Patient Information	
Patient Name:	DOB: Gender: M F
Address:	Phone:
City/ST/Zip:	Email:

All Preparations Are *PRESERVATIVE FREE* Unless Otherwise Specified.

Check Below	Cataract Surgery		*Quantity (mL)*
◯	Lotemax®	(0.5%)	5 mL
◯	Vigamox®	(0.5%)	3 mL
◯	Prolensa®	(0.07%)	3 mL
◯	Besivance®	(0.6%)	5 mL
◯	Gentamicin	(0.3%)	5 mL
◯	Prednisolone	(1.0%)	5 mL
◯	Durezol®	(0.05%)	5 mL

Other (*Please Specify*)

	Drug Name/Active Ingredient	Strength	Format/Quantity
1.	____________________	____________	____________

SIG:____

2.	____________________	____________	____________

SIG:____

____________________ ____________ ____________

Signature **Date** **Refills**

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