STAT DROPS™

PRESCRIBING SHEET

Hunt Valley PharmaLAB

NOVOTEARS™ We Make Eye Drops Personal™

OP DROPS™

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	ANTIBIOTICS			*QUANTITY (ML)*
◯ Vancomycin *(circle one)*	25 mg/mL	50 mg/mL		10 mL
◯ Tobramycin *(circle one)*	3 mg/mL	13.3 mg/mL (*Fortified*)		10 mL
◯ Gentamicin *(circle one)*	3 mg/mL	13.3 mg/mL (*Fortified*)		5 mL
◯ Ceftazidime	50 mg/mL			10 mL
CHECK BELOW	ANTIFUNGALS			*QUANTITY (ML)*
◯ Amphotericin B (5 mg/mL)				10 mL
◯ Voriconazole 1%				10 mL
CHECK BELOW	DRY EYES			*QUANTITY (ML)*
◯ Cyclosporine 1% with Artificial Tears				10 mL
◯ Glycerin 40% Solution				15 mL
◯ NovoTears (*serum tears, next-day)*	20%	33%	50%	*Max. Possible*

OTHER (*PLEASE SPECIFY*)

Drug Name/Active Ingredient	Strength	Format/Quantity
_____	_____	_____

SIG: _____

_____ _____ _____

Signature **Date** **Refills**

P: 410-667-6246
F: 410-666-7253

HV PharmaLabs / HV Pharmacy, Inc.
www.HVPCC.com

10 Warren Rd, Suite 220
Cockeysville, MD 21030