

COMPLETE & EMAIL TO pharmacist@optimushealth.co.nz

This document has been prepared for the supply of medicines pursuant to Section 26 of *the Medicines Act 1981* which provide the legal basis for the services offered by OPTIMUS HEALTHCARE 2025 LIMITED.

CONTRACT COMPOUNDING REQUEST FORM

Date:

Contact:

Clinic/Practice:

Street Address:

Phone:

Email:

Note: as this request is for **compounding service**, the following details are required (at minimum): *Medicine, Dose Strength/Concentration, Dose Form, Quantity/Supply Period*

Service Request – Prescription Compounding	Optimus Notes
Repeats:	
*Authorised by (Signature):	

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Repeats:	
*Authorised by (Signature):	

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Repeats:	
*Authorised by (Signature):	

*Prescriber's signature is required if the item being requested for compounding is a Prescription-only Medication

Labelling should include the expiry date provided by Optimus. As compounds are prepared to prescription or at the clinician's request, and because preservative use is kept to a minimum, we apply conservative expiry dates, which have been verified with the research department of the Professional Compounding Centres of America (PCCA).

Payment Terms: Unless otherwise arranged, payment is required upon receipt of the invoice.