

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* and Regulation 44 of the *Medicines Regulations 1984*, which provide the legal basis for the services offered by OPTIMUS HEALTHCARE 2025 LIMITED.

PHARMACY CONTRACT COMPOUNDING REQUEST FORM

Date: _____ Contact: _____

Pharmacy _____

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*

Medicine or Service Request	Quantity	Patient Name	Initial	Rpt.1	Rpt.2	STAT
1			#0	R1	R2	STAT
2			#0	R1	R2	STAT
3			#0	R1	R2	STAT
4			#0	R1	R2	STAT
5			#0	R1	R2	STAT

Conditions of Supply

1. A copy of the ORIGINAL PRESCRIPTION or Certified True Copy of the prescription must be emailed for each medicine request. Pharmacy-generated CRC repeat forms are NOT acceptable.
2. The requesting pharmacy is responsible for final packaging, labelling and issuing of expiry dates. Optimus supplies a suggested expiration date only.
3. The requesting pharmacy is responsible for record-keeping, dispensing and counselling of the receiving patient.
4. Optimus can only compound pursuant to a LEGAL and VALID prescription written by a NZ registered prescriber.

Labelling should include the expiry date provided by Optimus. As compounds are prepared to prescription or at the Doctors 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.

I hereby request Optimus to compound the above medicines for which I hold the original prescription.

Signed (Pharmacist): _____ Print Name: _____
