



866-236-5040 + pharmacist@pprpharmacy.com

Professional Pharmacy Resources is committed to ensuring reliable consistency, stable formulations, and convenient delivery options for your special compounded medication challenges!

Each compounded prescription is formulated with precise standards and is available in a wide range of palatable flavorings.



COMMONLY REQUESTED COMPOUNDED MEDICATIONS

	QUAD TABLET	MINI TABLET	CHEWABLE TABLET	SOFT CHEW	CAPSULE	LIQUID	TRANS-DERMAL
Amitriptyline	✓	✓	✓	✓	✓	✓	✓
Cisapride	✓	✓	✓	✓	✓	✓	✓
Clindamycin	✓	✓	✓	✓	✓	✓	
Diethylstilbestrol	✓	✓	✓	✓	✓	✓	
Doxycycline	✓	✓	✓	✓	✓	✓	
Enrofloxacin	✓	✓	✓	✓	✓	✓	
Fluconazole	✓	✓	✓	✓	✓	✓	
Fluoxetine	✓	✓	✓	✓	✓	✓	✓
Gabapentin	✓	✓	✓	✓	✓	✓	✓
Ketoconazole	✓	✓	✓	✓	✓	✓	
Levetiracetam	✓	✓	✓	✓	✓	✓	
Methimazole	✓	✓	✓	✓	✓	✓	✓
Metronidazole	✓	✓	✓	✓	✓	✓	
Phenylpropanolamine	✓	✓	✓	✓	✓	✓	
Pimobendan	✓	✓	✓	✓	✓	✓	
Piroxicam	✓	✓	✓	✓	✓	✓	✓
Ponazuril	✓	✓	✓	✓	✓	✓	
Potassium Bromide	✓	✓	✓	✓	✓	✓	
Prazosin	✓	✓	✓	✓	✓	✓	✓
Prednisolone	✓	✓	✓	✓	✓	✓	✓
Theophylline	✓	✓	✓	✓	✓	✓	
Triamcinolone	✓	✓	✓	✓	✓	✓	✓
Trilostane	✓	✓	✓	✓	✓	✓	
Ursodiol	✓	✓	✓	✓	✓	✓	

Why Use PPR as Your Veterinary Compounding Pharmacy?



Our friendly pharmacists provide individual consultation



FedEx 2Day Express shipping on all orders



We offer competitive pricing on medications



To inquire about other compounded products or to speak with one of our pharmacists, call us at 866-236-5040 or email pharmacist@pprpharmacy.com

Scan the QR Code to visit our new website!





PRESCRIPTION ORDER FORM

PRESCRIBER

Veterinarian Name: _____ Veterinarian License #: _____
 Clinic Name: _____ Office Contact Name: _____
 Phone #: _____ Fax#: _____ DEA#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Veterinarian Signature: _____ Date: _____

Pet Information

Pet Name: _____ Species: _____ Breed: _____
 DOB: _____ Weight: _____ lbs. Recorded Date: _____ Sex: Male Female
 Allergies: _____ Spayed/Neutered: Yes No
 Diagnosis: _____
 Pet Owner: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: _____

PRESCRIPTION

Medication	Strength	Directions	Quantity	Refills

Date Shipment Needed: _____ Ship to: Pet Owner Address Other Address
 Other Address: _____

Fax your prescription to: 866-685-7608 or email to: pharmacist@pprpharmacy.com.

We will contact you to verify your order and collect any additional information required.



866-236-5040



866-685-7608



pharmacist@pprpharmacy.com



pprpharmacy.com

This prescription may be filled at the pharmacy of the patient's choice.



PAYMENT AUTHORIZATION FORM

Please sign and complete this form based on your payment preference to PPR Pharmacy.

CUSTOMER INFORMATION

Name	
Address	
Email	

Payment Preference	<input type="checkbox"/> Automated Clearing House (Electronic)	<input type="checkbox"/> Check
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ACH DETAILS

Check one of the following	<input type="checkbox"/> Start	<input type="checkbox"/> Stop	<input type="checkbox"/> Changing Account Details
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NOTE: Please make sure every field is completed. Missing information will delay the process for direct deposit activation.

Bank Name		Name on Account	
Address		Account Type	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
City		Account Class	<input type="checkbox"/> Business <input type="checkbox"/> Personal
State		Bank Routing #	
Zip		Account #	

By signing this form, I authorize PPR Pharmacy to schedule regular debit payments from the account and Financial Institution named above. I understand this authorization will remain in effect until I cancel it in writing. I agree to notify PPR Pharmacy in writing of any changes to my account information or termination of this authorization at least 15 days prior to my next invoicing.

Signature		Date	
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Please attach a voided check for the account referenced above.