

 Fax

To: ImprimisRx

From: \_\_\_\_\_

Fax: 855-405-4669

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

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PROTECTED HEALTH INFORMATION

BUSINESS CONFIDENTIAL INFORMATION

**This fax is intended only for the exclusive use of the addressee(s), and may contain privileged or confidential information. If you are not the intended recipient, or the person responsible for delivering the fax to the intended recipient, be advised you have received this fax in error and that use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please destroy the attached document(s) and immediately notify the sender of the error.**

Please deliver to: \_\_\_\_\_ with this cover sheet to protect its contents.

**DATE TO BE ADMINISTERED** \_\_\_\_\_

**Patient Information**

Patient: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Age: \_\_\_\_ M \_\_\_\_ F \_\_\_\_ Tel: Home \_\_\_\_\_  
 Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Please allow for 24 hours turnaround time before order will ship.**

Incomplete orders may delay processing.

**Medication Allergies**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Shipping (check one)**

- FedEx Overnight     Bill to Office     Bill to Patient  
 FedEx 2 Day         Ship to Office     Ship to Patient  
 FedEx Ground

If you need a medication not listed, please contact us at **844-446-6979** (toll-free)

**Compounded Formulation**

Compounded Formulation	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty	# Refills
<input type="checkbox"/> Epinastine-Brimonidine PF (Epinastine HCL 0.05%, Brimonidine 0.025%)	5mL	<input type="checkbox"/> No commercial formulation available. <input type="checkbox"/> Other:	<input type="checkbox"/> Instill 1 drop, 2 times daily as directed <input type="checkbox"/> Other:		
<input type="checkbox"/> Other:					

Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice.  
 \*Representative formulation. Please contact us for an alternate formulation. Customizable within certain ranges.

Total prescriptions ordered

**Prescriber Verification**

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Prescriber Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 State License #: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_ Prescriber Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Payment Information**

Credit Card Number: \_\_\_\_\_ Expiration: \_\_\_\_\_ CVC/Code: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

**Patient Information (All fields required)**

First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			

When shipping multiple patients' prescriptions together to a physician or clinic, please indicate "Earliest Date to be Administered" on order form Page 1 to determine ship date.

The pharmacy will plan for all orders to arrive by one day prior to these dates.