	Fax							
To:	ImprimisRx	From:						
Fax:	855-405-4669	Fax:						
		Phone:						
		Number of Pages: Date:						
Comm	onto:							
Comm	ents:							
Г	PROTECTED HEALTH INFORMATION							
	BUSINESS CONFIDENTIAL INFORMATION							
in re co	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 recepient, or the person responsible for delivering the fax to the intended recepient, 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.							
PI	ease deliver to:	with this cover sheet to protect its contents.						



Integrative Injectable Order Form

Text: (858)264-2082 C	hat: imprimisrx.com
Email: or	der@imprimisrx.com
T DATE TO BE DELIVERED:	

atient Information	(, 202, 9	oriaor, i	address required)		ECT DATE TO	DE DEL 0/			
Patient:	DOB:		//	LAT	TEST DATE TO	BE DELIV	ERED:		
Age: MF Tel: Home					Medication	n Allerg	ies (require	d)	
Vork: Cell:					□NKDA	If allergi	ies are not	included	,
Address:						the patie	ent has NK	DA.	
City:	ST:	_ Zip	:						
Email Address:									
☐ Patient Profile(s)/Block Schedule Attache	ed				Detient Cli	inical In	formatio	m /!	14
Shipping (check one)					Patient Cli	micai in	iormatio	n (piease	select
☐ FedEx Overnight ☐ FedEx 2 Day ☐ FedEx Ground	d Ship to 0	Office	☐ Ship to Patient		☐ Integrative	9			
Please allow for 72 hours turnaround time (3 busine			•		Other:				
ncomplete orders may delay processing. If you need a mee fursuant to VA/OH/MO/VT law. Only 1 medication is permitted							shipped over		old
Compounded Formulation Injectable Medications	Size/Volu		_		Jse (REQUIRED			atient) #	Refills
¬ Ascorbic Acid†	4001		Infuse via IV						
(Non-Corn Source, 500mg/mL) PF	100mL		Inject via IM	_	mL time	es a week			
Dexpanthenol MDV (250mg/mL)	30mL		Infuse via IV						
	Oome		Inject via IM	_	mL time	es a week			
Dimercaptopropane Sulfonate DMPS PF (50mg/mL))* 5mL		Infuse via IV	_	mL time	es a week			
☐ Edetate Disodium EDTA PF (150mg/mL)	30mL		Infuse via IV		mL time	es a week			
7			Infuse via IV						
Glutathione (200mg/mL)*	30mL		Inject via IM		mL time	es a week			
7	20.1		Inject via IM						
Methylcobalamin (MB12) MDV (5mg/mL)*	30mL		SQ Infuse via IV	_	mL time	es a week			
Methylcobalamin (MB12) MDV (10mg/mL)*	30mL		Inject via IM						
	301112		SQ Infuse via IV	_	mL time	es a week			
MIC/Carnitine MDV (Pink) (25/50/50/50mg/mL)	30mL		Inject via IM						
who rearritance wild v (1 mm) (20/00/00/00/mg/mz)			SQ Infuse via IV		mL time	es a week			
Nicotinamide Adenine Dinucleotide (NAD)PF (100m	g/mL)* 10mL	╽╠	Infuse via IV Inject via IM		mL time	es a week			
<u> </u>		\vdash	Infuse via IV						
Pyridoxal 5 Phosphate MDV (100mg/mL)	30mL	∣⊣	Inject via IM	_	mL time	es a week			
		ΙĒ	Infuse via IV						
」 Taurine (L) MDV (50mg/mL)	30mL		Inject via IM	_	mL time	es a week			
¬ Vitamin B Complex with Hydroxocobalamin MDV			Inject via IM						
(1mg/mL) (Currently on backorder)	30mL		sQ	_	mL time	es a week			
ther									
Madical Navaration (Demoire different acception Acid Only 2					Total prescripti		d:		
Medical Necessity (Required for Ascorbic Acid Only) Proprofessional use only. ImprimisRx specializes in customizing medication				_			ıdividually identi	fied patients	
rith valid prescriptions. No compounded medication is reviewed by the FDA	for safety or efficac	y. Imprin	nisRx does not compound of	copies of	f commercially availab	le products. R	eferences availa	able upon req	uest.
rescribing Physician Verification ave reviewed my patient's medical record and determined the compound	ed medication(s) /	cupplies	ordered are medically pe	cossary	and that an EDA apr	proved drug is	not medically	annronriate I	vorify I
we examined and diagnosed the patient as indicated above. I will comply scription is to be dispensed as written unless otherwise instructed by me	with state and fede								
escriber Full Name:		P	hone:			Fax [.]			
ate License #:DE									
dress:									
siness/Clinic Name:									
p to Address (if different from above):								Zip:	
nail Address:									
escriber Signature:):		
ayment Information					‡T-		please provide		number
yor: Doctor Patient									
yer Beeter rationt									
thod of Payment: New Credit Card Number:	F	-4!	01.10	VO :1	. 5"	lin n 7 !			F2



Commercial Products Order Form

Text: (858)264-2082 Chat: imprimisrx.com

Email: order@imprimisrx.com

Patient Information	(Name, DOB, gender	, address required)			ii. order@iiripi	1111151 X.COIII
Patient:	DOB:	/ /	LATEST DATE TO	BE DELIVER	ED:	
Age: MF Tel: Home			Medication	n Allergies	(required)	
Work: Cell:			□NKDA	If allergies	are not include	ed,
Address:				the patient	has NKDA.	
City:	_ST: Zi	p:				
Email Address:		<u> </u>				
☐ Patient Profile(s)/Block Schedule Attach	ed		Patient CI	inical Info	rmation (pleas	as solest one)
Shipping (check one)			_		illiation (pieas	se select one)
☐ FedEx Overnight ☐ FedEx 2 Day ☐ FedEx Groun	nd Ship to Office	☐ Ship to Patient				
Please allow for 72 hours turnaround time (3 busin	• .	•	-			
Incomplete orders may delay processing. If you need a m Pursuant to VA/OH/MO/VT law. Only 1 medication is permitted				ns must be sh idicates prese	ipped overnight ervative-free.	cold
Formulation / Item	Size/Volume	Instruction	ns for Use (REQUIRED))*	Qty (per patient)	# Refills
_						
Magnesium Chloride - 20% - Multi-Dose	50mL	☐ Infuse via IV	mLtime	s a week		
Magnesium Sulfate - 50% - Single-Use	10mL	☐ Infuse via IV	mL time	s a week		
Calcium Chloride - PF 10%	401	□ Infina via IV				
Calcium Chloride - PF 10%	10mL	☐ Infuse via IV	mLtime	s a week		
Calcium Gluconate - PF 10%	10mL	☐ Infuse via IV	mL time	s a week		
_		_				
Syringe / Needle	3mL 25G x 1in	Use as directed				
Other						
					l	
			Total prescription	ons ordered:		
			rotal procomptic	ondorod.		
For professional use only. ImprimisRx specializes in customizing medicatio with valid prescriptions. No compounded medication is reviewed by the FD						
Prescribing Physician Verification						
have reviewed my patient's medical record and determined the compoun						
nave examined and diagnosed the patient as indicated above. I will compl prescription is to be dispensed as written unless otherwise instructed by m		cumentation requirements	by retaining a copy of this pre	scription in the pa	alient's medical record	. The
Prescriber Full Name:		Phone:		_ Fax:		
State License #:D						
Address:		-			•	
Business/Clinic Name:						
Ship to Address (if different from above):						
Email Address:						
Prescriber Signature:		Date:		romo Code: _	ase provide a cellphor	ne number
Payment Information Payor: ☐ Doctor ☐ Patient			111	o pay by text, plea	ase provide a celiphor	ie numbei
Method of Payment:						
New Credit Card Number:	Expiration:	CV0	C/Code: Bil	ling Zip:		p on File
Crodit Card on File Ending In:	odo:	nucios mo usina mu	, DDEADDDOVED Not	20 tormo		

Patient Information (All fields required)					
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
					NKDA
		Number of Refills:	N/A		
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
		Number of Refills:	N/A		
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
					Ш
		Number of Refills:	N/A		
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
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		Number of Refills:	N/A		
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
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		N CD. CII.	NI/A		
		Number of Refills:	N/A		_
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
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		N CD. CII.	NI/A		
		Number of Refills:	N/A		_
First & Last Name	Birthdate		Address	Known Drug Allergies	
					NKDA
		Number of Defini	NI/A		
		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.