

Phone: (844) 446-6979 Fax: (855) 405-4669

Patient:	Patient Information	(Name, DOB, gende		3d)	O BE ADMINIST	ERED	
Work	Patient:	DOB:	//	Med	ication Allergi	es (required	i)
Address: City:	•						
City:	Work:Cell:						
Patient Profile(s)/Block Schedule Attached Patient Profile(s)/Block Schedule Attached Patient Profile(s)/Block Schedule Attached Shiping (check one) Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 72 hours turnaround time (3 business days) before order will ship. Integrative Other Please allow for 62 dediction from 1 the 1 business days for 2 business days) before order will ship. Integrative Other Please allow for 62 dediction from 1 the 1 business days) for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 the 1 business days for 62 dediction from 1 business days	Address:						
Patient Profile (s) Block Schedule Attached	City:	ST: Z	<u> </u>				
Patient Profile(s)/Block Schedule Attached Integrative Other: Other	Email Address:			— Pati	ent Clinical Inf	ormatio	1 (please select
Gedits verwight Fedits Ze Day Fedits Ground Ship to Office Ship to Patient	☐ Patient Profile(s)/Block Schedule Atta	ached					· ·
Pelese allow for 72 hours turnaround time (3 business days) before order will ship. Incomplete orders may delay processing. I you need a mediation nel steet, please callow for Parametric Of-Mont/Visic. Worly if mediation is permitted per order form. Please use a new form of additional form. Compounded Formulation	Shipping (check one)				•		
Incomplete orders may delay processing. If you need a medication and latest, please calculate as a 44-44-459 (trail-free). Portionate to Ord/Not/Order order form. Please use a medication and latest, please calculate as a 44-44-459 (trail-free). Compounded Formulation Ascorbite Addit (Non-Com Source, 500mg/mL) PF	☐ FedEx Overnight ☐ FedEx 2 Day ☐ FedEx G	round	e Ship to P	atient 🔲 🔾			
Compounded Formulation	Incomplete orders may delay processing. If you need	a medication not listed, pleas	e contact us at 844-4	146-6979 (toll-free).	** Maximum of 3	vials per p	atient. [*]
Ascorbic Acid† (Non-Com Source, 500mg/mL) PF		•			for Use (Required)		Qty
(Non-Corn Source, 500mg/mL) PF	Injectable Medications						
Methylcobalamin (MB12) MDV (fmg/mL)** 30mL			100mL				
Methylcobalamin (MB12) MDV (5mg/mL)** 30mL Methylcobalamin (MB12) MDV (10mg/mL)** 30mL MIC/Carnitine MDV (Pink) 30mL Vitamin B Complex with Hydroxocobalamin 30mL Total prescriptions ordered Pyridoxal 5 Phosphate MDV (100mg/mL)* 30mL there Total prescriptions ordered Total prescript	Glutathione 200mg/ml		30mL				
Methylcobalamin (MB12) MDV (10mg/mL)** 30mL Molt/Carnitine MDV (Pink) (25/50/50/50/ml) 30mL Vitamin B Complex with Hydroxocobalamin 30mL Pyridoxal 5 Phosphate MDV (100mg/mL)* 30mL other	☐ Methylcobalamin (MB12) MDV (1mg/mL)**		30mL				
MIG/Carnitine MDV (Pink) 30mL	☐ Methylcobalamin (MB12) MDV (5mg/mL)**		30mL				
(25/50/50/50/fo) Sumin B Complex with Hydroxocobalamin MDV (1mg/mL)* 30mL	☐ Methylcobalamin (MB12) MDV (10mg/mL)**		30mL				
MDV (1mg/mL)* Pyridoxal 5 Phosphate MDV (100mg/mL)* 30mL other			30mL				
other	☐ Vitamin B Complex with Hydroxocobalamin MDV (1mg/mL) *		30mL				
Thedical Necessity (Required for Ascorbic Acid Only)Please state the medical necessity for choosing non-corn Ascorbic Acid: **For professional use only. ImprimisRx specializes in customizing medications to meet unique patient and practitioner needs. ImprimisRx dispenses these formulations only to individually identified patients with valid prescriptions. No compounded medication is reviewed by the FDA for safety or efficacy. ImprimisRx does not compound copies of commercially available products. References available upon reviewed my patient's medical record and determined the compounded medication(s) / supplies ordered are medically necessary and that an FDA approved drug is not medically appropriate. I verify I we 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 secribion is to be dispensed as written unless otherwise instructed by me. **Rescriber Full Name:** **Phone:** **Phone:** **Phone:** **Pax:** **Japan:** **Japan:**	Pyridoxal 5 Phosphate MDV (100mg/mL)*		30mL				
Please state the medical necessity for choosing non-corn Ascorbic Acid: For professional use only. ImprimisRx specializes in customizing medications to meet unique patient and practitioner needs. ImprimisRx dispenses these formulations only to individually identified patients with valid prescriptions. No compounded medication is reviewed by the FDA for safety or efficacy. ImprimisRx does not compound copies of commercially available products. References available upon revescribing Physician Verification aver reviewed my patients medical record and determined the compounded medication(s) / supplies ordered are medically necessary and that an FDA approved drug is not medically appropriate. I verify to 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 scription is to be dispensed as written unless otherwise instructed by me. Phone: Phone: Phone: Fax: DEA: NPI: Email:	other			Tot	tal prescriptions ord	ered	
with valid prescriptions. No compounded medication is reviewed by the FDA for safety or efficacy. ImprimisRx does not compound copies of commercially available products. References available upon recessing Physician Verification ave reviewed my patients medical record and determined the compounded medication(s) / supplies ordered are medically necessary and that an FDA approved drug is not medically appropriate. I verify I we 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 secription is to be dispensed as written unless otherwise instructed by me. Phone: Phone: Fax: DEA: NPI: Email: diress: City: ST: Zip: mail Address: prior to Address (if different from above): Date: ayment Information ayor: Doctor Facility Patient Patient Patient Deta: Deta: Date: Date: Date: Doctor Facility Patient Ethod of Payment:							
rescribing Physician Verification ave reviewed my patient's medical record and determined the compounded medication(s) / supplies ordered are medically necessary and that an FDA approved drug is not medically appropriate. I verify I ve 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 secreption is to be dispensed as written unless otherwise instructed by me. Phone: Phone:							
ave reviewed my patient's medical record and determined the compounded medication(s) / supplies ordered are medically necessary and that an FDA approved drug is not medically appropriate. I verify i we 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 secription is to be dispensed as written unless otherwise instructed by me. Phone:		the FDA for safety or efficacy.	ImprimisRx does not	compound copies of co	mmercially available produ	ucts. Reference	es available upon requ
ve 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 escription is to be dispensed as written unless otherwise instructed by me. Phone: Fax:	• ,						
Phone:							
DEA:	escription is to be dispensed as written unless otherwise instructed by	/ me.					
City:	escriber Full Name:		Phone:		Fax:		
Isiness/Clinic Name: Office Contact: Inip to Address (if different from above): City: ST: Zip: Inip to Address (if different from above): Date: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip: Inip to Address (if different from above): ST: Zip:	ate License #:	DEA:	NPI:		Email:		
nail Address (if different from above): City: ST: Zip: escriber Signature: Date: ayment Information ayor: Doctor Facility Patient ethod of Payment:	ldress:		City:		ST:	Zip:	
mail Address:	usiness/Clinic Name:		_ Office Co	ontact:			
escriber Signature: Date: ayment Information ayor: Doctor Facility Patient ethod of Payment:	ip to Address (if different from above):			City:		_ ST:	_ Zip:
ayment Information ayor:	nail Address:						
ayment Information ayor:	escriber Signature:		Date:				
·	ayment Information						
New Credit Card Number: Expiration: CVC/Code: Billing Zip:	ethod of Payment:						
	New Credit Card Number:	Expiration:		CVC/Code:	Billing Zip:		Keep on File

FAX FORM TO: (855) 405-4669