Fax

To: ImprimisRx

Fax: 855-405-4669

From: _____

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

☐ PROTECTED HEALTH INFORMATION

☐ BUSINESS CONFIDENTIAL INFORMATION

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

ImprimisRx Order Form

imprimis Rx®

Text: (858)264-2082 **Chat:** imprimisrx.com
Email: info@imprimisrx.com

Order Date: _____ **Earliest Date to be Administered:** _____

Patient Information

Patient: _____ DOB: ____/____/____
Age: _____ M ○ F ○ Tel: Home _____ _____
Work: _____ _____ Cell: _____ _____
Address: _____
City: _____ ST: _____ Zip: _____
Email Address: _____

Please allow for 72 hours turnaround time (3 business days) 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	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty	# Refills
Topical Medications					
☐ Mydriagel (Phenylephrine/Tropicamide/Ketorolac Tromethamine/Moxifloxacin) 2.5%/1%/0.4%/0.5%*	**5mL**	☐ No commercial formulation available. ☐ Other:	☐ To be administered topically by the physician ☐ Other:		
☐ 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: _____

FAX FORM TO: (855) 405-4669

Patient Information (All fields required)

First & Last Name	Birthdate	Address	Known Drug Allergies
			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 ☐
	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 ☐
	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 ☐
	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.

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