

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

Compounded Formulation	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty	# Refills
<input type="checkbox"/> Mydrigel (Phenylephrine/Tropicamide/Ketorolac Tromethamine/Moxifloxacin) 2.5%/1%/0.4%/0.5%*	5mL	<input type="checkbox"/> No commercial formulation available. <input type="checkbox"/> Other:	<input type="checkbox"/> To be administered topically by the physician <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.

 Fax

To: ImprimisRx

From: _____

Fax: 855-405-4669

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

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.