imprimis Rx®

Ophthalmic Topical Order Form

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

Patient Information (Name, DOB, gender, address required)

Patient: _____ DOB: ____/____/____
Age: _____ M___F___ Tel: Home _____ _____
Work: _____ _____Cell: _____ _____
Address: _____
City: _____ ST: _____ Zip: _____
Email Address: _____

☐ Patient profile(s)/block schedule attached ☐ If patient is unreachable, ship to verified address above

Shipping

Priority Cold-Overnight shipping included ☐ Ship to Office ☐ Ship to Patient

Delivery the next business morning by 9:30 am to most areas. Additional extended delivery locations are guaranteed up to 2:00 pm.

Pursuant to VA/OH/MO/VT law. Only 1 medication is permitted per order form. Please use a new form for additional items.

DATE TO BE ADMINISTERED _____

Medication Allergies (required)

☐ NKDA **If allergies are not included, the patient has NKDA.**

_____
_____
_____

Patient Clinical Information (please select one)

☐ Ophthalmic
☐ Other: _____

Incomplete orders may delay processing.

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

Orders with complete information and payment will ship within 24 hours (1 business day) of receipt.

Combination Formulations*	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty	# Refills
☐ Tobramycin 1.5% / Vancomycin 5% Ophthalmic Solution	☐ 7mL	☐ No commercial formulation available. ☐ Other: _____	☐ 2 drops every two hours while awake for 3 days and then tapered until gone. ☐ 1 drop every two hours while awake for 3 days and then tapered until gone. ☐ _____		
☐ Other:					
			Total prescriptions ordered		

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.

*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 request.

Prescribing Physician Verification

I have 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 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 Full Name: _____ Phone: _____ Fax: _____
State License #: _____ DEA: _____ NPI: _____ Email: _____
Address: _____ City: _____ ST: _____ Zip: _____
Business/Clinic Name: _____ Office Contact: _____
Ship to Address (if different from above): _____ City: _____ ST: _____ Zip: _____
Email Address: _____
Prescriber Signature: _____ Date: _____

Payment Information

Payor: ☐ Doctor ☐ Facility ☐ Patient

Method of Payment:

☐ New Credit Card Number: _____ Expiration: _____ CVC/Code: _____ Billing Zip: _____ ☐ Keep on File
☐ Credit Card on File Ending In: _____ CVC/Code: _____ ☐ Invoice me using my PREAPPROVED Net-30 terms

This form is not permitted for AL patients

FAX FORM TO: (855) 405-4669