imprimis Rx®

Glaucoma Order Form - "Simple 10" Evaluation

Phone: (844) 446-6979 Fax: (949) 551-1950

Patient Information

Patient: ______________________ DOB: ____/____/____

Age: ______ M____F____ Tel: Home ______ ______________

Work: ______ ______________ Cell: ______ ______________

Address: ______________________________

City: ______________________ ST: ______ Zip: ________

Email Address: ______________________________

☐ If patient is unreachable, ship to verified address above

Medication Allergies

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

____

____

Shipping (check one)

US Postal Service (included)

Orders with Latanoprost will go overnight with a cold pack.

Please allow for 72 hours turnaround time (3 business days) before order will ship. Incomplete orders may delay processing.

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

Staff initials required

Payment Information

Payor: ☐ Doctor ☐ Facility ☐ Patient

Method of Payment:

CODE: SIMPLE10

Start any new patient on a Simple Drops formulation for just $10 for their first 2-month prescription*, shipping included.

☐ 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 offer expires August 31, 2017. Offer is valid for new patients and new prescriptions only, any refills that are filled will be charged full price.

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

Preservative-Free Compounded Formulation	Size/Volume	Instructions for Use	Qty	# Refills
Topical Medications				
☐ LAT PF (Latanoprost, 0.005%)**	5mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
☐ TIM-LAT PF (Timolol/Latanoprost, 0.5/0.005%)**	5mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
☐ BRIM-DOR PF (Brimonidine/Dorzolamide, 0.15/2%)**	10mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
☐ TIM-DOR-LAT PF (Timolol/Dorzolamide/Latanoprost, 0.5/2/0.005%)**	5mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
☐ TIM-BRIM-DOR PF (Timolol/Brimonidine/Dorzolamide, 0.5/0.15/2%)**	10mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
☐ TIM-BRIM-DOR-LAT PF (Timolol/Brimonidine/Dorzolamide/Latanoprost, 0.5/0.15/2/0.005%)**	5mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
☐ TIM-BRIM-DOR PF (Timolol/Brimonidine/Dorzolamide, 0.5/0.15/2%)**	10mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
TIM-BRIM-DOR-LAT PF (Timolol/Brimonidine/Dorzolamide/Latanoprost (0.5/0.15/2/0.005%)**	5mL	☐ OD ☐ BID ☐ QHS ☐ OS ☐ TID ☐ OU		☐ 1 ☐ 4 ☐ 2 ☐ 5 ☐ 3
		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.

Prescribing Physician 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 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: ______________

FAX FORM TO: (949) 551-1950