imprimis Rx®

Custom Compound Order Form

Have Questions? Call us today!

CUSTOMER SERVICE: (949) 551-7195

FAX ORDER TO: (949) 551-1950

Order Date: _____

Incomplete orders may delay processing.

Patient Information

Patient: _____ MRN#_____ DOB:____/_____/_____

Age: _____ M◯ F◯ Tel: Home _____ _____

Work: _____ _____Cell: _____ _____

Address: _____

City: _____ ST: _____ Zip:_____

Email Address: _____

Medication Allergies

_____

_____

_____

Shipping (check one)

☐ Ship to Office ☐ Ship to Patient

☐ Pick up at an ImprimisRx Pharmacy

Payment Information

☐ Credit Card Number: _____ Expiration: _____ CVC/Code: _____ Billing Zip: _____ ☐ Keep on File

All formulations are shipped frozen and shipped overnight except atropine

If you need a medication not listed, please contact us at **949-551-1795** (toll-free)

Compounded Formulation**	Size/Volume	Instructions for Use (Required)	Quantity	Refills
☐ Vancomycin 50mg/mL Preservative-Free	10mL bottles		☐ 10mL ☐ _____	
☐ Vancomycin 25mg/mL Preservative-Free	10mL bottles		☐ 10mL ☐ _____	
☐ Tobramycin 15mg/mL Preservative-Free	10mL bottles		☐ 10mL ☐ _____	
☐ Polyhexamethylene Biguanide 0.02% Preservative-Free	10mL bottles		☐ 10mL ☐ _____	
☐ Chlorhexidine Gluconate 0.02% Preservative-Free	10mL bottles		☐ 10mL ☐ _____	
☐ Atropine Sulfate 0.01%	5mL bottles		☐ 5mL ☐ _____	
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.

Prescriber 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: _____

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

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