ORDERING THROUGH YOUR EMR SYSTEM

e-Scribing Benefits

By e-scribing through your existing Electronic Medical Record (EMR) system, your prescriptions will be sent directly to our pharmacy for processing which may expedite turnaround time.

INSTRUCTIONS

Please follow the steps below to properly start utilizing your EMR system.

1

Locate the pharmacy

You can find the ImprimisRx pharmacy in your EMR system as identified below:

ImprimisRx NJ, LLC
1705 Route 46, Suite 4
Ledgewood, NJ 07852
866-792-7328

2

Complete the information

Once the pharmacy is chosen, please complete the following information:

- **Patient information** (please be sure your patient profile has name, phone number, address and date of birth complete in your EMR so demographics will transmit to our system)
- **Search medication and select** (Search one of the ingredients of the compound. Example: search "cyclosporine" for Cyclosporine in Klarity/Klarity-C)
- **Select the correct quantity**

  Please note certain formulations will have more than one size so be sure to select the correct fill size. Please select which is preferred. Klarity-C is sold in 3 bottles (5.5mL bottles), totaling 16.5mL. Please save 16.5mL as the default for Klarity-C.

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3 Provide Instructions for Use:

Please indicate dosing instructions—how the formulation will be administered, volume to be used, and how often the drops are to be applied.

> STEROID-ANTIBIOTIC-ANTI-INFLAMMATORY AGENT 5ML or 8ml
> (ie: Prednisolone-Gatifloxacin-Bromfenac - 5ml)
>
> Instill __X___ drop(s) into affected eye ___X___ times a day
> for ____X_____ days.

4 Include Doctor Notes

Please include in the Notes to Pharmacy field.

- Dispense ImprimisRx Compound (ie: "Prednisolone Acetate-Gatifloxacin-Bromfenac" or "Pred-Gati-Brom"-5mL)
  **Needed only if formulation cannot be selected in EMR*
- Medical Necessity (ie: patient cannot tolerate commercial formulation, patient needs double strength, etc.) ***Please note: financial/economic reason is not valid.*** **Required*
- Patient allergies _____ **Required*
- Ship to Patient or Doctor, Bill to Patient or Doctor **Required*
- Medication start date _____, Surgery date _____ **if applicable*

For assistance with EMR setup or if you have questions, please contact us at: EMRsupport@imprimisrx.com