ImprimisRx® Avenova Order Form

imprimis Rx®

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

Patient Information

Patient: _____ DOB: ____/____/____
Age: _____ M ◯ F ◯ Tel: Home _____
Work: _____ Cell: _____
Address: _____
City: _____ ST: _____ Zip: _____
Email Address: _____

Please allow for 24 hours turnaround time before order will ship.
Incomplete orders may delay processing.
If you need a medication not listed, please contact us at **844-446-6979** (toll-free)

DATE TO BE ADMINISTERED _____

Medication Allergies (required)

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

Shipping (check one)

◯ FedEx Overnight ◯ Bill to Office ◯ Bill to Patient
◯ FedEx 2 Day ◯ Ship to Office ◯ Ship to Patient
◯ FedEx Ground

Formulation	Size/Volume	Instructions for Use (Required)	Qty	# Refills
Topical Medications				
☐ Avenova® (pure hypochlorous acid, 0.01% as a preservative) spray solution	**40mL**	☐ Apply to affected eye(s) twice daily ☐ Other: _____		
☐ 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 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

HSA/FSA Cards Accepted

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

FAX FORM TO: (855) 405-4669

This form is not permitted for AL patients