



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)

Table with 5 columns: Compounded Formulation, Size/Volume, Instructions for Use (Required), Quantity, Refills. Rows include Vancomycin 50mg/mL, 25mg/mL, Tobramycin 15mg/mL, Polyhexamethylene Biguanide 0.02%, Chlorhexidine Gluconate 0.02%, Atropine Sulfate 0.01%, and Other.

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: \_\_\_\_\_

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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