imprimis Rx®

Total Tears® Order Form

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

Incomplete orders may delay processing.

Patient Information

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

Shipping (check one)

☐ Ship to Office ☐ Ship to Patient

Shipping Method

☐ Fedex Ground ☐ Fedex Priority Overnight ☐ Fedex 2-Day

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

DATE TO BE ADMINISTERED _____

Medication Allergies

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

Patient Clinical Information

☐ Ophthalmic
☐ Other: _____

Orders with complete information will ship within 24 hours (1 business day) of receipt.

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

Compounded Formulation*	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Quantity	Refills
☐ Klarity Drops (Glycerin and Dextran Based Vehicle Ophthalmic Solution PF)	10mL Bottle	☐ No commercial product available. ☐ Other: _____	☐ Instill 1 drop, twice daily as directed ☐ Other: _____	10mL	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11
☐ Klarity-A Drops (Azithromycin 1% Ophthalmic Solution PF)	3.5mL Bottle	☐ No commercial product available. ☐ Other: _____	☐ Instill 1 drop, twice daily as directed ☐ Other: _____	3.5mL	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11
■ Klarity-C (Cyclosporine 0.1% Ophthalmic Emulsion PF)	5.5mL Bottle	☐ Patient cannot tolerate commercial formulation. ☐ Other: _____	☐ Instill 1 drop, twice daily as directed ☐ Other: _____	■ 5.5mL ☐ 16.5mL	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ■11 ☐9 ☐10
☐ Klarity-L (Loteprednol 0.5% Ophthalmic Suspension PF)	5mL Bottle	☐ Patient cannot tolerate commercial formulation. ☐ Other: _____	☐ Instill 1 drop, twice daily as directed ☐ Other: _____	5mL	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11
■ Klarity-CL (Cyclosporine 0.1%/ Loteprednol Etabonate 0.2% Ophthalmic Suspension PF)	5mL Bottle	☐ No commercial product available. ☐ Other: _____	☐ Instill 1 drop, twice daily as directed ☐ Other: _____	5mL	■1 ■2 ☐3 ■4 ■5 ☐6 ■7 ■8 ☐9 ☐10 ☐11
☐ 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 _____

*For professional use only. ImprimisRx specializes in customizing medications to meet unique patient and practitioner needs. ImprimisRx dispenses these formulations only to individually identified patients with valid prescriptions. No compounded medication is reviewed by the FDA for safety or efficacy. ImprimisRx does not compound essentially copies of commercially available products. References available upon request.

Prescriber Verification

I have reviewed my patient's medical record and determined the compounded 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 Signature: _____ Date: _____ Office Contact: _____

Prescriber Full Name: _____ Phone: _____ Fax: _____

State License #: _____ DEA: _____ NPI: _____ Prescriber Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Payment Information

Payor: ☐ Facility ☐ Patient

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

Patient Information (All fields required)

First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: N/A		

When shipping multiple patients' prescriptions together to a physician or clinic, please indicate *"Earliest Date to be Administered"* on order form Page 1 to determine ship date.

<u>The pharmacy will plan for all orders to arrive by one day prior to these dates.</u>

Fax

To: ImprimisRx

Fax: 855-405-4669

From: _____

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: 2 months therapy for $70 - Klarity-CL and Klarity-C

☐ PROTECTED HEALTH INFORMATION

☐ BUSINESS CONFIDENTIAL INFORMATION

Please deliver to: _____ with this cover sheet to protect its contents.