imprimis Rx®

Total Tears™ Order Form

Have Questions? Call us today!

CUSTOMER CARE: (844) 446-6979 FAX: (855) 405-4669

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: _____

Shipping (check one)

☐ Ship to Office ☐ Ship to Patient

Shipping Method

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

Medication Allergies

_____

_____

_____

Patient Clinical Information

☐ Ophthalmology

☐ Other: _____

Please allow for 72 hours (3 business days) turn around time before order will ship.

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
☐ Doxycycline/Omega-3 AR 10mg*	#180 Capsules Per Bottle	☐ No commercial formulation available. Cannot tolerate drops. ☐ Other: _____	☐ Take 2 capsules, once daily ☐ Other: _____	180 Capsules	☐1 ☐4 ☐2 ☐5 ☐3
☐ Omega-3 AR 500mg*	#360 Capsules Per Bottle	☐ No commercial formulation available. Cannot tolerate drops. ☐ Other: _____	☐ Take 2 capsules, twice daily ☐ Other: _____	360 Capsules	☐1 ☐4 ☐2 ☐5 ☐3
☐ Klarity-C (Cyclosporine 0.1%/Chondriotin Sulfate Preservative-Free Ophthalmic Emulsion*)	5.5mL Bottle	☐ Patient cannot tolerate commercial formulation. ☐ Other: _____	☐ Instill 1 drop, twice daily as directed ☐ Other: _____	☐ 16.5mL (3 x 5.5mL bottles) ☐ Other _____	☐1 ☐2 ☐3
☐ Klarity (Chondroitin Sulfate Preservative-Free Ophthalmic Emulsion*)	10mL Bottle	☐ No commercial product available. ☐ Other: _____		10mL	☐1 ☐4 ☐7 ☐10 ☐2 ☐5 ☐8 ☐11 ☐3 ☐6 ☐9
☐ Other _____	___ Capsules				

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.

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

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 Signature:_____ Date: _____ Office Contact: _____

Prescriber Full Name:_____ Phone:_____ Fax:_____

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

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

Email Address: _____

Payment Information

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