

 Fax

To: ImprimisRx

From: _____

Fax: 855-405-4669

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

PROTECTED HEALTH INFORMATION

BUSINESS CONFIDENTIAL INFORMATION

This fax is intended only for the exclusive use of the addressee(s), and may contain privileged or confidential information. If you are not the intended recipient, or the person responsible for delivering the fax to the intended recipient, be advised you have received this fax in error and that use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please destroy the attached document(s) and immediately notify the sender of the error.

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

Patient Information

(Name, DOB, gender, address required)

Patient: _____ DOB: ____/____/____

Age: _____ M____F____ Tel: Home _____

Work: _____ Cell: _____

Address: _____

City: _____ ST: _____ Zip: _____

Email Address: _____

Patient Profile(s)/Block Schedule Attached

Shipping (check one)

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

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

Incomplete orders may delay processing. If you need a medication not listed, please contact us at **858-345-1961** (toll-free).

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

* Items must be shipped overnight cold
PF indicates preservative-free.

LATEST DATE TO BE DELIVERED: _____

Medication Allergies (required)

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

Patient Clinical Information (please select one)

Integrative

Other: _____

Compounded Formulation	Injectable Medications	Size/Volume	Instructions for Use (REQUIRED)*	Qty (per patient)	# Refills
<input type="checkbox"/> Ascorbic Acid† (Non-Corn Source, 500mg/mL) PF		100mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Dexpantenol MDV (250mg/mL)		30mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Dimercaptopropane Sulfonate DMPS PF (50mg/mL)*		5mL	<input type="checkbox"/> Infuse via IV _____ mL _____ times a week		
<input type="checkbox"/> Edetate Disodium EDTA PF (150mg/mL)		30mL	<input type="checkbox"/> Infuse via IV _____ mL _____ times a week		
<input type="checkbox"/> Glutathione (200mg/mL)*§		30mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Methylcobalamin (MB12) MDV (5mg/mL)*§		30mL	<input type="checkbox"/> Inject via IM <input type="checkbox"/> SQ <input type="checkbox"/> Infuse via IV _____ mL _____ times a week		
<input type="checkbox"/> Methylcobalamin (MB12) MDV (10mg/mL)*§		30mL	<input type="checkbox"/> Inject via IM <input type="checkbox"/> SQ <input type="checkbox"/> Infuse via IV _____ mL _____ times a week		
<input type="checkbox"/> MIC/Carnitine MDV (Pink) (25/50/50/50mg/mL)		30mL	<input type="checkbox"/> Inject via IM <input type="checkbox"/> SQ <input type="checkbox"/> Infuse via IV _____ mL _____ times a week		
<input type="checkbox"/> Nicotinamide Adenine Dinucleotide(NAD)PF (100mg/mL)*		10mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Pyridoxal 5 Phosphate MDV (100mg/mL)		30mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Taurine (L) MDV (50mg/mL)		30mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Vitamin B Complex PF* (Minimum 10 vials per order)		5mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> Vitamin B Complex with Cyanocobalamin (1mg/mL)PF* (Minimum 10 vials per order)		5mL	<input type="checkbox"/> Infuse via IV <input type="checkbox"/> Inject via IM _____ mL _____ times a week		
<input type="checkbox"/> other					

Total prescriptions ordered: _____

†Medical Necessity (Required for Ascorbic Acid Only) Please state the medical necessity for choosing non-corn Ascorbic Acid:

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 copies of commercially available products. References available upon request.

Prescribing Physician Verification

I have reviewed my patient's medical record and determined the compounded medication(s) / supplies ordered are medically necessary and that an FDA approved drug is not medically appropriate. 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: _____ Cell Phone†: _____

Prescriber Signature: _____ Date: _____ Promo Code: _____

Payment Information

Payor: Doctor Patient

‡To pay by text, please provide a cellphone number

§Not available to ship to California

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

(Name, DOB, gender, address required)

Patient: _____ DOB: ____/____/____

Age: _____ M____F____ Tel: Home _____

Work: _____ Cell: _____

Address: _____

City: _____ ST: _____ Zip: _____

Email Address: _____

Patient Profile(s)/Block Schedule Attached

Shipping (check one)

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Medication Allergies (required)

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

Patient Clinical Information (please select one)

Integrative

Other: _____

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Formulation / Item	Size/Volume	Instructions for Use (REQUIRED)*	Qty (per patient)	# Refills
<input type="checkbox"/> Calcium Chloride - PF 10%	10mL	<input type="checkbox"/> Infuse via IV ____ mL ____ times a week		
<input type="checkbox"/> Calcium Gluconate - PF 10%	10mL	<input type="checkbox"/> Infuse via IV ____ mL ____ times a week		
<input type="checkbox"/> Magnesium Chloride - 20% - Multi-Dose	50mL	<input type="checkbox"/> Infuse via IV ____ mL ____ times a week		
<input type="checkbox"/> Magnesium Sulfate - 50% - Single-Use	10mL	<input type="checkbox"/> Infuse via IV ____ mL ____ times a week		
<input type="checkbox"/> Syringe / Needle	3mL 25G x 1in	Use as directed		
<input type="checkbox"/> Zinc Chloride PF (1mg/mL)	10mL	<input type="checkbox"/> Infuse via IV ____ mL ____ times a week		
<input type="checkbox"/> Other				

Total prescriptions ordered: _____

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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: _____ Cell Phone*: _____

Prescriber Signature: _____ Date: _____ Promo Code: _____

Payment Information

Payor: Doctor 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

Patient Information (All fields required)

First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
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.

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