Fax

To: ImprimisRx

Fax: 855-405-4669

From: _____

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

☐ PROTECTED HEALTH INFORMATION

☐ BUSINESS CONFIDENTIAL INFORMATION

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

imprimis Rx®

Integrative Injectable Order Form

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

LATEST DATE TO BE DELIVERED: _____

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

Medication Allergies (required)

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

Patient Clinical Information (please select one)

☐ Integrative
☐ Other: _____

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.

Compounded Formulation Injectable Medications	Size/Volume	Instructions for Use (REQUIRED)*	Qty (per patient)	# Refills
☐ Ascorbic Acid† (Non-Corn Source, 500mg/mL) PF	100mL	☐ Infuse via IV ☐ Inject via IM ____ mL ____ times a week		
☐ Dexpanthenol MDV (250mg/mL)	30mL	☐ Infuse via IV ☐ Inject via IM ____ mL ____ times a week		
☐ Dimercaptopropane Sulfonate DMPS PF (50mg/mL)*	5mL	☐ Infuse via IV ____ mL ____ times a week		
☐ Edetate Disodium EDTA PF (150mg/mL)	30mL	☐ Infuse via IV ____ mL ____ times a week		
☐ Glutathione (200mg/mL)*	30mL	☐ Infuse via IV ☐ Inject via IM ____ mL ____ times a week		
☐ Methylcobalamin (MB12) MDV (5mg/mL)*	30mL	☐ Inject via IM ☐ SQ ☐ Infuse via IV ____ mL ____ times a week		
☐ Methylcobalamin (MB12) MDV (10mg/mL)*	30mL	☐ Inject via IM ☐ SQ ☐ Infuse via IV ____ mL times a week		
☐ MIC/Carnitine MDV (Pink) (25/50/50/50mg/mL)	30mL	☐ Inject via IM ☐ SQ ☐ Infuse via IV ____ mL ____ times a week		
☐ Nicotinamide Adenine Dinucleotide (NAD)PF (100mg/mL)*	10mL	☐ Infuse via IV ☐ Inject via IM ____ mL ____ times a week		
☐ Pyridoxal 5 Phosphate MDV (100mg/mL)	30mL	☐ Infuse via IV ☐ Inject via IM ____ mL ____ times a week		
☐ Taurine (L) MDV (50mg/mL)	30mL	☐ Infuse via IV ☐ Inject via IM ____ mL ____ times a week		
☐ Vitamin B Complex with Hydroxocobalamin MDV (1mg/mL) (Currently on backorder)	30mL	☐ Inject via IM ☐ SQ ____ mL ____ times a week		
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: _____
‡To pay by text, please provide a cellphone number

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

FAX FORM TO: (855) 405-4669

This form is not permitted for AL patients

imprimis Rx®

Commercial Products Order Form

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

LATEST DATE TO BE DELIVERED: _____

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

Medication Allergies (required)

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

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.

Patient Clinical Information (please select one)

☐ Integrative
☐ Other: _____

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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.

Formulation / Item	Size/Volume	Instructions for Use (REQUIRED)*	Qty (per patient)	# Refills
☐ Magnesium Chloride - 20% - Multi-Dose	50mL	☐ Infuse via IV ____ mL ____ times a week		
☐ Magnesium Sulfate - 50% - Single-Use	10mL	☐ Infuse via IV ____ mL ____ times a week		
☐ Calcium Chloride - PF 10%	10mL	☐ Infuse via IV ____ mL ____ times a week		
☐ Calcium Gluconate - PF 10%	10mL	☐ Infuse via IV ____ mL ____ times a week		
☐ Syringe / Needle	3mL 25G x 1in	Use as directed		
☐ 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: _____
‡To pay by text, please provide a cellphone number

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

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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.

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