Fax

To: ImprimisRx

Fax: 855-405-4669 **Phone:** 844-446-6979

From: ____________________

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 recepient, or the person responsible for delivering the fax to the intended recepient, 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.

*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.

imprimis Rx®

MKO Melt Order Form

Phone: (844) 446-6979 Fax: (855) 405-4669

Patient Information (Name, DOB, gender, address, phone required)

Patient: ______________________ DOB: ____/_____/_____

Age: ______ M___F___ Tel: Home ______ ____________

Work: ______ ______________Cell: ______ ____________

Address: ______________________

City: ______________________ ST: _______ Zip: __________

Email Address: ______________________

Driver's License or State Issued ID Number*: ______________

☐ Patient Profile(s)/Block Schedule Attached

# of Patients _____

Please allow for 72 hours turnaround time (3 business days) before order will ship.
Incomplete orders may delay processing.

DATE TO BE ADMINISTERED ______________

Medication Allergies (required)

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

____

____

Shipping

Patient requests to receive prescription at prescriber ASC. _______
Staff initials required

Patient Clinical Information (please select one)

☐ Ophthalmology

☐ Other: ______________________

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

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

Compounded Formulation	Instructions for Use	Price	Qty per patient††
Midazolam / Ketamine HCL/Ondansetron Sublingual Lemon (3/25/2)mg†	Dissolve sublingually prior to procedure as instructed by prescriber.	$15 per melt	

Total prescriptions ordered: ___________

†Unused prescription medication should be discarded in conformance with all state and federal laws. The use of a reverse distributor is recommended. Ensure to keep all accurate controlled substance records.

††If ordering for more than one patient, please use the attached form.

Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice
Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss.

REMINDER: Please check patient information has been included before submitting.

Prescribing Physician 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.

If multiple prescribing physicians, use separate order form for each.

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: ____________

Payment Information

Payor: ☐ Doctor ☐ Facility

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

*Required patient information for the following states: Kentucky, Tennessee, Louisiana, Pennsylvania, Oklahoma, Kansas and Michigan.

Patient Information (Name, DOB, address, phone, allergies required)

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
QTY: ______	Patient requests to receive prescription at prescriber ASC. __________ Staff initials required		Driver's License Number or State Issued ID Number*: ________________	**If allergies are not included, the patient has NKDA.**
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
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