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.

Other Topical Order Form

Patient Information

Patient: _____ DOB: ____/_____/_____

Age: _____ M___F___ Tel: Home _____ _____

Work: _____ _____Cell: _____ _____

Address: _____

City: _____ ST: _____ Zip:_____

Email Address: _____

Please allow for 24 hours turnaround time 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 (check one)

☐ FedEx Overnight ☐ Bill to Office ☐ Bill to Patient

☐ FedEx 2 Day ☐ Ship to Office ☐ Ship to Patient

☐ FedEx Ground

Compounded Formulation*	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty	#Refills
Topical Medications					
☐ Mydriatic 2 (Tropicamide/Phenylephrine Hydrochloride) 1/2.5%	**5mL**	☐ No commercial formulation available. ☐ Other:	☐ To be administered topically by the physician ☐ Other:		
☐ Mydriatic 3 (Tropicamide/Cyclopentolate/Phenylephrine) 1/1/2.5%	**1mL**	☐ No commercial formulation available. ☐ Other:	☐ To be administered topically by the physician ☐ Other:		
☐ Mydriatic 4 (Tropicamide/Proparacaine/Phenylephrine/Ketorolac Tromethamine) 1/0.5/2.5/0.5%**	**5mL**	☐ No commercial formulation available. ☐ Other:	☐ To be administered topically by the physician ☐ Other:		
☐ Atropine Sulfate PF 0.01%	**5mL**	☐ No commercial formulation available. ☐ Other:	☐OD ☐QD ☐OS ☐Other:_____		
☐ Atropine Sulfate PF 0.025%	**5mL**	☐ No commercial formulation available. ☐ Other:	☐OD ☐QD ☐OS ☐Other:_____		
☐ Atropine Sulfate PF 0.05%	**5mL**	☐ No commercial formulation available. ☐ Other:	☐OD ☐QD ☐OS ☐Other:_____		
☐ 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.

**Shipped cold overnight.

Total prescriptions ordered: _____

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 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 ☐ 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

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.