Ophthalmic Topical Order Form

imprimis Rx®

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

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 ☐ If patient is unreachable, ship to verified address above

DATE TO BE ADMINISTERED _____

Medication Allergies (required)

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

Patient Clinical Information (please select one)

☐ Ophthalmic
☐ Other: _____

Shipping (check one)

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

Pursuant to VA/OH/MO/VT law. Only 1 medication is permitted per order form. Please use a new form for additional items.
Orders with complete information will ship within 24 hours (1 business day) of receipt.

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

Combination Formulations*	Size/Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty	# Refills
☐ Pred-Moxi-Brom (Prednisolone **Acetate**/Moxifloxacin/Bromfenac) (1/0.5/0.075)%	☐ **5mL** ☐ **8mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Pred-Gati-Brom (Prednisolone **Acetate**/Gatifloxacin/Bromfenac) (1/0.5/0.075)%	☐ **5mL** ☐ **8mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Pred-Gati-Brom (Prednisolone **Phosphate**/Gatifloxacin/Bromfenac) (1/0.5/0.075)%	☐ **5mL** ☐ **8mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Pred-Moxi-Nepaf (Prednisolone **Acetate**/Moxifloxacin/Nepafenac) (1/0.5/0.1)%	☐ **5mL** ☐ **8mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Pred-Moxi (Prednisolone **Acetate**/Moxifloxacin) (1/0.5)%	**5mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Pred-Brom (Prednisolone **Acetate**/Bromfenac) (1/0.075)%	**5mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Pred-Nepaf (Prednisolone **Acetate**/Nepafenac) (1/0.1)%	**5mL**	☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ TID ☐ QID		
☐ Prednisolone Acetate Preservative-Free 1%	**5mL**	☐ No commercial formulation available. ☐ Other:	☐ OD ☐ OS ☐ TID ☐ QID		
☐ 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.

Total prescriptions ordered

*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: _____
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

FAX FORM TO: (855) 405-4669

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.

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.