imprimis Rx®

Ophthalmic Topical Order Form

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

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)

☐ Ophthalmology

☐ 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.

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 **844-446-6979** (toll-free).

Compounded Formulation	Size/Volume	Instructions for Use (REQUIRED)	Qty	# Refills
Topical Medications				
☐ Pred-Gati (Prednisolone Acetate/Gatifloxacin) 1/0.5%*	**3.5mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Pred-Gati-Brom (Prednisolone Acetate/Gatifloxacin/Bromfenac) 1/0.5/0.075%*	**3.5mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Pred-Gati-Brom (Prednisolone Acetate/Gatifloxacin/Bromfenac) 1/0.5/0.075%*	**7mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Pred-Gati (Prednisolone Phosphate/Gatifloxacin) 1/0.5%*	**3.5mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Pred-Brom (Prednisolone Phosphate/Bromfenac) 1/0.075%*	**3.5mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Pred-Gati-Brom (Prednisolone Phosphate/Gatifloxacin /Bromfenac) 1/0.5/0.075%*	**3.5mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Pred-Gati-Brom (Prednisolone Phosphate/Gatifloxacin /Bromfenac) 1/0.5/0.075%*	**7mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ Other:		
☐ Prednisolone Acetate Preservative-Free 1%*	**5mL**	☐ Instill 1 drop in affected eye(s) 3 times daily as directed by physician. ☐ Instill 1 drop in affected eye(s) 4 times daily as directed by physician. ☐ 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.

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 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: _____

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

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

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐

☐ Ship to Patient ☐ Ship to Clinic | Rx Start Date: | Number of Refills: | Paid by: ☐ Physician/Clinic ☐ Patient

Credit Card Number: ________________ Expiration: ____/____ CVC Code: ______ Billing Zip: ______ ☐ If patient is unreachable, ship to verified address above

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
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☐ Ship to Patient ☐ Ship to Clinic | Rx Start Date: | Number of Refills: | Paid by: ☐ Physician/Clinic ☐ Patient

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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.
When shipping individual prescriptions directly to patients, indicate *"Rx Start Date"* for each on Page 2.

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