

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

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.

Incomplete orders may delay processing.

Please allow for 72 hours turnaround time (3 business days) before order will ship.

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

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: _____

Compounded Formulation

Size/Volume

Instructions for Use (REQUIRED)

Qty

Refills

Topical Medications

<input type="checkbox"/> Pred-Gati (Prednisolone Acetate/Gatifloxacin) 1/0.5%*	3.5mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Pred-Brom (Prednisolone Acetate/Bromfenac) 1/0.075%*	3.5mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 2 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Pred-Gati-Brom (Prednisolone Acetate/Gatifloxacin/Bromfenac) 1/0.5/0.075%*	3.5mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Pred-Gati-Brom (Prednisolone Acetate/Gatifloxacin/Bromfenac) 1/0.5/0.075%*	7mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Mydriatic 3 (Tropicamide/Cyclopentolate/Phenylephrine) 1/1/2.5%*	1mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Mydriatic 4 (Tropicamide/Proparacaine/Phenylephrine/Ketorolac Tromethamine) 1/0.5/2.5/0.5%*	1mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Atropine 0.01%*	5mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 1 time daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 2 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Povidone Iodine 5%*	1mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> Prednisolone Acetate Preservative-Free 1%	5mL	<input type="checkbox"/> Instill 1 drop in affected eye(s) 3 times daily as directed by physician. <input type="checkbox"/> Instill 1 drop in affected eye(s) 4 times daily as directed by physician. <input type="checkbox"/> Other:		
<input type="checkbox"/> 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