

 Fax

To: ImprimisRx

From: _____

Fax: 855-405-4669

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

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

Shipping (check one)

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

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 **858-446-6979** (toll-free).
 Pursuant to VA/OH/MO/VT law. Only 1 medication is permitted per order form. Please use a new form for additional items.

DATE TO BE ADMINISTERED

Medication Allergies (required)

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

Patient Clinical Information

Disease State: _____

Compounded Formulation	Size/Volume	Medical Necessity (required)	Instructions for Use	# Refills
Chronic Infectious Disease				
<input type="checkbox"/> Pyrimethamine 12.5mg/Leucovorin 2.5mg Oral Capsule**	_____ capsules			
<input type="checkbox"/> Pyrimethamine 25mg/Leucovorin 5mg Oral Capsule**	_____ capsules			
<input type="checkbox"/> Pyrimethamine 25mg/Leucovorin 10mg Oral Capsule**	_____ capsules			
<input type="checkbox"/> Pyrimethamine 50mg/Leucovorin 10mg Oral Capsule**	_____ capsules			
<input type="checkbox"/> Pyrimethamine 50mg/Leucovorin 20mg Oral Capsule**	_____ capsules			
<input type="checkbox"/> Pyrimethamine 50mg/Leucovorin 25mg Oral Capsule**	_____ capsules			
Urology				
<input type="checkbox"/> PPS** (pentosan polysulfate sodium E4M) 150mg Capsule	_____ capsules			
<input type="checkbox"/> PPS** (pentosan polysulfate sodium E4M) 200mg Capsule	_____ capsules			
other		Total prescriptions ordered		
<small>*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.</small>				

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 essentially 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

Patient Information (All fields required)

First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
Number of Refills: N/A			
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA <input type="checkbox"/>
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.