imprimis Rx®

Ophthalmic Topical Order Form

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

Patient Information

Patient: _____ DOB: ____/____/____
Age: _____ M☐ F☐ Tel: Home _____ _____
Work: _____ _____ Cell: _____ _____
Address: _____
City: _____ ST: _____ Zip: _____
Email Address: _____

☐ If patient is unreachable, ship to verified address above

Ship to: ☐ Patient ☐ Facility

Please allow for 72 hours turnaround time (3 business days) before order will ship.
Incomplete orders may delay processing.

Shipping (check one)

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

DATE TO BE ADMINISTERED _____

Medication Allergies

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

Patient Clinical Information (please select one)

☐ Ophthalmic
☐ Other: _____

Additional fees apply for upgraded shipping.
PF indicates preservative-free
If you need a medication not listed, please contact us at **844-446-6979** (toll-free).

Preservative-Free Compounded Formulation*	Size/Volume	Medical Necessity (required)	Instructions for Use	Qty	# Refills
Topical Medications 1gtts					
☐ LAT PF (Latanoprost, 0.005%)**	7.5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (7.5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-LAT PF (Timolol/Latanoprost, 0.5/0.005%)**	5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ BRIM-DOR PF (Brimonidine/Dorzolamide, 0.15/2%)	10mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (10mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-DOR-LAT PF (Timolol/Dorzolamide/Latanoprost, 0.5/2/0.005%)**	5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-BRIM-DOR PF (Timolol/Brimonidine/Dorzolamide, 0.5/0.15/2%)	5mL (2 bottles per shipment)	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 2 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-BRIM-DOR-LAT PF (Timolol/Brimonidine/Dorzolamide/Latanoprost, 0.5/0.15/2/0.005%)**	5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-BRIM-DOR-BIM PF (Timolol/Brimonidine/Dorzolamide/Bimatoprost, 0.5/0.15/2/0.01%)	5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-BRIM-DOR PF (Timolol/Brimonidine/Dorzolamide, 0.5/0.15/2%)	5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QAM	☐ 1 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ TIM-BRIM-DOR-LAT PF (Timolol/Brimonidine/Dorzolamide/Latanoprost, 0.5/0.15/2/0.005%)**	5mL	☐ Patient needs preservative free. ☐ Patient has trouble with multiple bottle regimen. ☐ Other: _____	☐ OD ☐ OS ☐ QD ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle (5mL) ☐ Other _____	☐1 ☐2 ☐3 ☐4 ☐5
☐ Other:					

Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice.
Important: Patients may need to take more than one eye drop product pursuant to multiple dosing regimens, as directed by his or her prescriber, in order for the active ingredients to remain effective throughout the day.

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 essentially copies of commercially available products. References available upon request.
**Shipped overnight cold.

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: _____ Cell Phone‡: _____

Prescriber Signature: _____ Date: _____

Promo Code: _____
‡To pay by text, please provide a cellphone number

Payor: ☐ Doctor ☐ 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.

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

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.