Prescriber signature on the form is required for processing.

Fax

To: ImprimisRx

Fax: 855-405-4669 **Phone:** 844-446-6979

You may also submit the prescription via the **Prescriber Portal** at: *prescribe.imprimisrx.com*

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.

Incomplete orders may delay processing.
*Indicates required field

Other Topical Order Form

Patient Information

Patient Name*: _____ DOB*: ____/____/____ M ○ F ○

Tel: Home _____ _____ Work: _____ _____ Cell: _____ _____

Address*: _____ City*: _____ ST*: _____ Zip*: _____

Email Address: _____ HIPAA Authorized Caregiver _____

Pursuant to VA/OH/MO/VT law. Only 1 medication is permitted per order form. Please use a new form for additional items.

Shipping (check one) ☐ Ship to Office ☐ Ship to Patient **Date Needed** ____/____/____

Medication Allergies (Required to Dispense) ☐ NKDA **If allergies are not included, the patient has NKDA.**

_____

_____

Compounded Formulation	Bottle Volume	Medical Necessity (Required)	Instructions for Use (Required)	Qty (# of Bottles)	Refills
☐ Klarity Drops (Glycerin 1% Ophthalmic Solution PF)	**10mL**	☐ No commercial formulation available. ☐ Other:	☐ OD ☐ OS ☐ Frequency: _____		☐1 ☐4 ☐7 ☐10 ☐2 ☐5 ☐8 ☐11 ☐3 ☐6 ☐9
☐ Klarity-A Drops (Azithromycin 1% Ophthalmic Solution PF)	**3.5mL**	☐ No commercial formulation available. ☐ Other:	☐ OD ☐ OS ☐ Frequency: _____		☐1 ☐4 ☐7 ☐10 ☐2 ☐5 ☐8 ☐11 ☐3 ☐6 ☐9
☐ Klarity-C Drops (Cyclosporine 0.1% Ophthalmic Emulsion PF)	**5.5mL**	☐ No commercial formulation available. ☐ Other:	☐ OD ☐ OS ☐ Frequency: _____		☐1 ☐4 ☐7 ☐10 ☐2 ☐5 ☐8 ☐11 ☐3 ☐6 ☐9
☐ Klarity-L Drops (Loteprednol 0.5% Ophthalmic Suspension PF)	**5mL**	☐ No commercial formulation available. ☐ Other:	☐ OD ☐ OS ☐ Frequency: _____		☐1 ☐4 ☐7 ☐10 ☐2 ☐5 ☐8 ☐11 ☐3 ☐6 ☐9
☐ Klarity-CL Drops (Cyclosporine 0.1%/ Loteprednol 0.2% Ophthalmic Suspension PF)	**5mL**	☐ No commercial formulation available. ☐ Other:	☐ OD ☐ OS ☐ Frequency: _____		☐1 ☐4 ☐7 ☐10 ☐2 ☐5 ☐8 ☐11 ☐3 ☐6 ☐9

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.

Prescriber Verification

I have reviewed my patient's medical record and determined the compounded 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 Signature: _____ Date: _____

*Prescriber Full Name: _____ *Phone: _____ *Fax: _____

State License #: _____ DEA: _____ *NPI: _____ Prescriber Specialty: _____

*Address: _____ *City: _____ *ST: _____ *Zip: _____

Business/Clinic Name: _____ Office Contact: _____

Ship to Address _____ City: _____ ST: _____ Zip: _____

Email Address: _____

Payment Information

Payor: ☐ Facility ☐ Patient

Method of Payment:

To provide new credit card information visit www.payfordrops.com.

☐ 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
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA ☐
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		
First & Last Name	Birthdate	Address	Known Drug Allergies
			NKDA
	Number of Refills: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11		

When shipping multiple patients' prescriptions together to a physician or clinic, please indicate "Earliest Date Needed" on order form Page 1 to determine ship date.