imprimis Rx

Ophthalmic Topical Order Form

Phone: (844) 446-6979 Fax: (949) 551-1950

Patient Information

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

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

DATE TO BE ADMINISTERED _____

Medication Allergies

_____
_____
_____

Shipping (check one)

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

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

Compounded Formulation	Size/Volume	Instructions for Use	Qty	# Refills
Topical Medications				
☐ Pred-Moxi (Prednisolone Acetate/Moxifloxacin Hydrochloride) 1/0.5%**	**3mL**	Instill into the affected eye(s) following the instructions provided by your prescriber		
☐ Pred-Moxi (Prednisolone Acetate/Moxifloxacin Hydrochloride) 1/0.5%**	**6mL**	Instill into the affected eye(s) following the instructions provided by your prescriber		
☐ Pred-Ketor (Prednisolone Acetate/Keterolac Tromethamine) 1/0.4%**	**3mL**	Instill into the affected eye(s) following the instructions provided by your prescriber		
☐ Pred-Moxi-Ketor (Prednisolone Acetate/Moxifloxacin Hydrochloride/Keterolac Tromethamine) 1/0.5/0.4%**	**3mL**	Instill into the affected eye(s) following the instructions provided by your prescriber		
☐ Pred-Moxi-Ketor (Prednisolone Acetate/Moxifloxacin Hydrochloride/Keterolac Tromethamine) 1/0.5/0.4%**	**6mL**	Instill into the affected eye(s) following the instructions provided by your prescriber		
☐ Pred-Moxi-Nepaf (Prednisolone Acetate/Moxifloxacin Hydrochloride/Nepafenac) 1/0.5/0.1%**	**5mL**	Instill into the affected eye(s) following the instructions provided by your prescriber		
☐ Mydriatic 3 (Tropicamide/Cyclopentolate/Phenylephrine) 1/1/2.5%**	**1mL**			
☐ Mydriatic 4 (Tropicamide/Cyclopentolate/Phenyleph-rine/Ketorolac Tromethamine) 1/0.5/2.5/0.5%**	**1mL**			

*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.

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: _____ Zip: _____

Email Address: _____

Prescriber Signature:_____ Date: _____

Payment Information

☐ Invoice (NET 30) ☐ Pay by credit card on file ☐ Paid by patient

Credit Card Number:_____ Expiration:_____ CVC/Code:_____ Billing Zip: _____

FAX FORM TO: (949) 551-1950

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

Patient Information

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
				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
				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
				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
				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
				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

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.

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