imprimis Rx®

DRUG SHORTAGE - ORDER FORM

Phone: (844) 446-6979 Fax: (855) 405-4669

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.

Medication Allergies

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

_____

_____

Shipping (check one)

☐ US Postal Service (Included - patient shipping only)

☐ FedEx 2-Day ☐ FedEx Overnight

☐ FedEx Saturday

Additional fees apply for upgraded shipping.

Patient Clinical Information (please select one)

☐ Ophthalmology

☐ Other: _____

Payment Information

Payor: ☐ Facility ☐ Patient

☐ Credit Card Number: _____ Expiration: _____ CVC/Code: _____ Billing Zip: _____ ☐ Keep on File

☐ Invoice me using my PREAPPROVED Net-30 terms

Medical Necessity

☐ Commercial drug is currently not availble to my patient.

☐ _____

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	Instructions for Use	Qty	# Refills
Topical Medications *1gtts*				
☐ Dorzolamide 2% and Timolol 0.5% Ophthalmic Solution Preservative-Free	**10mL**	☐ OD ☐ OS ☐ OU ☐ BID ☐ QHS	☐ 1 Bottle ☐ Other _____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Dorzolamide 2% Ophthalmic Solution Preservative-Free	**10mL**	☐ OD ☐ OS ☐ OU ☐ BID ☐ TID ☐ QHS	☐ 1 Bottle ☐ Other _____	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice.

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 commerciallyavailable 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: _____ Zip: _____

Email Address: _____

Prescriber Signature: _____ Date: _____

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

FAX FORM TO: (855) 405-4669