imprimis Rx

Fax

To: Park Compounding

Fax: 949-551-1950 **Phone:** 858-704-4644

From: _____

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

_____

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☒ 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 recepient, 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: Order Fulfillment with this cover sheet to protect its contents.

imprimis Rx

Fax to 949-551-1950

Order Date: ____/____/_____ **Date Needed By/Date of Administration:** ____/____/_____

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

Prescriber Information

Required

Prescriber Name: _____

DEA: _____ NPI#: _____

Center/Clinic: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Primary Contact: _____

Email: _____

***If multiple prescribing physicians, use separate order form for each.**

Patient Information

Required

Patient Name: _____

Birthdate: ____/____/_____ Phone: (_____) _____ - _____

Address: _____

_____

Known Drug Allergies: _____

_____

☐ No Known Drug Allergies (NKDA)

Patient Profile(s) or Block Schedule Attached: YES NO (circle one)

# of Patients*: _____

☐ Patient requests to pick up prescription at prescriber clinic. _____
Staff initials

If you need a medication not listed, please contact us at **866-551-7195** (toll-free)

Medication and Strength	Size/Volume	Directions	Quantity
Midazolam / Ketamine HCL/Ondansetron Sublingual Lemon (3/25/2)mg†	Troche 2-Pack	Dissolve 1-2 troches sublingually prior to procedure as instructed by prescriber.	

†Unused prescription medication should be discarded in conformance with all state and federal laws. The use of a reverse distributor is recommended. Ensure to keep all accurate controlled substance records.

Other _____

*Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice
**Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss.

REMINDER: Please check patient information has been included before submitting.

Order Submission

THIS FORM CONSTITUTES A PRESCRIBER'S ORDER/PRESCRIPTION WHEN SIGNED BY THE PRESCRIBER

Please FAX with cover sheet to ImprimisRx
949-551-1950

Authorized Prescriber's Signature
X _____

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

# of Prescriptions _____

Payment Information

IF NO CREDIT CARD ON FILE AND YOU ARE NOT CURRENTLY BEING INVOICED, PLEASE SUBMIT THE FOLLOWING:

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

This form is provided in an effort to improve patient safety.

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 ☐
☐ Patient requests to pick up prescription at prescriber clinic. ________ Staff initials				
First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
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