# Fax

**To:** ImprimisRx

**Fax:** 858-225-3410 **Phone:** 866-551-7195

From: ____________________

Fax: ____________________

Phone: ____________________

Number of Pages: __________ Date: ____________________

Comments: ____________________

☐ 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 recepient, 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: ____________________ with this cover sheet to protect its contents.

imprimis Rx

# Urology Order Form

Phone: **866-551-7195** (toll-free)

**Order Date:** ____/____/________ **Earliest Date To Be Administered:** ____/____/________

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

## Physician Information (Required)

Prescribing Physician: ______________________

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

# of Patients*: ________

Paid by: ☐ Physician/Clinic ☐ Patient

Ship to: ☐ Physician/Clinic ☐ Patient

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

## Medication Orders

| Medication | Strength or Concentration | Size/Volume | Instructions for use | Catheter | Quantity | # Refills |
|---|---|---|---|---|---|---|
| ☐ **Hep-Lido-A**** (alkalinized lidocaine, heparin) | **Heparin 66,000u/Lido HCl 265mg per syringe**** *alternate* __________ | **20ml single-use syringe kit** | **Instill into the bladder through a catheter per physician instructions given at office visit** | ☐ Male (12 fr) ☐ Female (8fr) ☐ Pediatric (6fr) | | |
| | Directions: | | | | | |

**Quantity provided is based on a 30-day supply.**

*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 for all medications before submitting.**

## Order Submission

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

Please FAX with cover sheet to ImprimisRx

**858-225-3410**

Authorized Physician'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.**

Current as of 9/21/15 v1

**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 | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |
| First & Last Name | Birthdate | Address | Phone Number | Known Drug Allergies |
| | | | | NKDA ☐ |
| ☐ Ship to Patient ☐ Ship to Clinic | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |
| First & Last Name | Birthdate | Address | Phone Number | Known Drug Allergies |
| | | | | NKDA ☐ |
| ☐ Ship to Patient ☐ Ship to Clinic | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |
| First & Last Name | Birthdate | Address | Phone Number | Known Drug Allergies |
| | | | | NKDA ☐ |
| ☐ Ship to Patient ☐ Ship to Clinic | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |
| First & Last Name | Birthdate | Address | Phone Number | Known Drug Allergies |
| | | | | NKDA ☐ |
| ☐ Ship to Patient ☐ Ship to Clinic | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |
| First & Last Name | Birthdate | Address | Phone Number | Known Drug Allergies |
| | | | | NKDA ☐ |
| ☐ Ship to Patient ☐ Ship to Clinic | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |
| First & Last Name | Birthdate | Address | Phone Number | Known Drug Allergies |
| | | | | NKDA ☐ |
| ☐ Ship to Patient ☐ Ship to Clinic | Number of Refills: | | Paid by: ☐ Physician/Clinic ☐ Patient | |

☐ Unless otherwise indicated above, all patients identified with this order do not have allergies to any of the ingredients within the Hep-Lido-A compounded formulation.