Fax

To: Pharmacy Creations

Fax: 855-405-4669 toll-free
973-328-8731

Phone: 858-704-4045

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.

imprimis Rx

Urology Order Form

Phone: **858-704-4644**

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 (circle one)

# of Patients*: _____

Paid by: ☐ Physician/Clinic ☐ Patient

Ship to: ☐ Physician/Clinic ☐ Patient

If you need a medication not listed, please contact us at **858-704-4644**

Medication	Strength or Concentration	Size/Volume	Instructions for use	Catheter	Quantity
☐ **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 ☐ Female ☐ Pediatric	_____ syringe(s) ☐ daily ☐ weekly ☐ monthly
	Directions:				# Refills
☐ **Elmiron®*** (pentosan polysulfate sodium)	**Elmiron® 100mg capsule**	**90 capsules**	**1 capsule by mouth 3 times a day**	n/a	Quantity / # Refills
☐ **PPS-DR**** (pentosan polysulfate sodium delayed release)	**150mg delayed release capsule**** *alternate*_____	**60 capsules**	**1 capsule by mouth 2 times a day or as instructed at your doctor visit**	n/a	Quantity / # Refills

*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 Pharmacy Creations

855-405-4669 or (toll-free) **973-328-8731**

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 10/7/15 v5

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.