GLAUCOMA DROPS ORDER FORM

Fax1: 406-541-6267 | Fax2: 406-493-0757

Patient: _____ DOB: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: _____ Allergies: _____ ❒ No Known Allergies

Email: _____

Timolol 0.5% **Latanoprost 0.005%** *BAK 0.01%* Ophthalmic Solution Drops 3.5 ml bottle # of Bottles:_____ Refills:_____ **Directions:** Instill 1 drop in OS / OD / OU eye(s) **Please circle one** QD / BID / TID / QID **Please circle one** AM / PM **Please circle one** **OR:**	**Timolol 0.5%** **Brimonidine 0.2%** **Dorzolamide 2%** *BAK 0.01%* Ophthalmic Solution Drops 3.5 ml bottle # of Bottles:_____ Refills:_____ **Directions:** Instill 1 drop in OS / OD / OU eye(s) **Please circle one** QD / BID / TID / QID **Please circle one** AM / PM **Please circle one** **OR:**	**Timolol 0.5%** **Brimonidine 0.2%** **Dorzolamide 2%** **Latanoprost 0.005%** *BAK 0.01%* Ophthalmic Solution Drops 3.5 ml bottle # of Bottles:_____ Refills:_____ **Directions:** Instill 1 drop in OS / OD / OU eye(s) **Please circle one** QD / BID / TID / QID **Please circle one** AM / PM **Please circle one** **OR:**	**Morning and Evening Combination** **AM** **Timolol 0.5%** **Brimonidine 0.2%** **Dorzolamide 2%** *BAK 0.01%* **PM** **Timolol 0.5%** **Brimonidine 0.2%** **Dorzolamide 2%** **Latanoprost 0.005%** *BAK 0.01%* Ophthalmic Solution Drops 3.5 ml bottles # of Bottles of each:_____ Refills:_____ **Directions:** Instill 1 drop in OS / OD / OU eye(s) **Please circle one** QD / BID / TID / QID **Please circle one** **OR:**

All orders received will be processed by the following business day for shipping.
All fields required. Incomplete orders may delay processing.

I have reviewed my patients medical record and determined the medication(s) 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 patients' medical record. The prescription is to be dispensed as written unless otherwise instructed.

Prescriber Signature: _____ Prescriber Name: _____ NPI # _____

Facility Name: _____ Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Prescriber Email: _____

Shipping: ❒ Ship to Office ❒ Ship to Patient **Payment:** ❒ Doctor ❒ Patient ❒ Pharmacy call patient for payment

Credit Card Number: _____ Exp: _____ CVC: _____

Credit Card on file ending in: _____

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