PREDNISOLONE 1%, BROMFENAC 0.075% ORDER FORM

Fax: 866-515-0196

☐ **Prednisolone 1%, Bromfenac 0.075% Topical Ophthalmic Solution**	**PO#**_____
Total # of 4 ml bottles: _____	
Directions: Instill 1 drop in OS / OD / OU eye(s) *Please circle one*	
QD / BID / TID / QID *Please circle one*	

Date(s) of surgery: _____ Please only prescribe one medication per form. Use additional forms as needed.

Patient Name	DOB	Address	Allergies	# of Bottles
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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: _____

Credit Card Number: _____ Exp: _____ CVC: _____

Credit Card on file ending in: _____ Date: _____

Compounds are available by prescription only. The FDA does not approve compounds to cure, treat, or mitigate disease. This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and/ or telephone number set forth herein and obtain instructions as to the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.