OPHTHALMIC TOPICAL ORDER FORM

PROMO CODE _____

Fax: 866-515-0196

Patient Information (Name, DOB, gender, address required)

Patient: _____ DOB: ____/____/____

M ____ F ____ Tel: Home _____

Cell: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

❑ Patient profile(s)/block schedule attached ❑ If patient is unreachable, ship to verified address above

Shipping (check one)

❑ Ship to Office ❑ Ship to Patient

SURGERY DATE: _____

Medication Allergies (required)

❑ NKDA *If allergies are not included, the patient has NKDA.*

_____

_____

Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice.

Pursuant to VA/OH/MO/VT law. Only 1 medication is permitted per order form. Please use a new form for additional items.

All orders received will be processed by the following business day for shipping.

Compounded Formulation	Size/Volume	Qty.	Medical Necessity *(required)*	Instructions for Use *(required)*	# Refills
Topical Medications	**Select Only One Size**				
❑ Prednisolone Phosphate/Gatifloxacin 1% / 0.5%	**3.5mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ OD ❑ TID ❑ OS ❑ QID ❑ BID	
❑ Prednisolone Phosphate/Gatifloxacin/Bromfenac 1% / 0.5% / 0.075%	❑ **4mL** ❑ **7mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ OD ❑ TID ❑ OS ❑ QID ❑ BID	
❑ Prednisolone Phosphate/Bromfenac 1% / 0.075%	**4mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ OD ❑ TID ❑ OS ❑ QID ❑ BID	
❑ Prednisolone Phosphate/Gatifloxacin/Ketorolac 1% / 0.5% / 0.5%	❑ **4mL** ❑ **7mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ OD ❑ TID ❑ OS ❑ QID ❑ BID	
❑ Prednisolone Phosphate/Ketorolac 1% / 0.5%	**4mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ OD ❑ TID ❑ OS ❑ QID ❑ BID	
❑ Timolol/Latanoprost 0.5% / 0.005%	**3.5mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ BID ❑ QD	
❑ Timolol/Brimodinine Tartrate/Dorzolamide 0.5% / 0.2% / 2%	**3.5mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ BID ❑ QD	
❑ Timolol/Brimodinine Tartrate/Dorzolamide/Latanoprost 0.5% / 0.2% / 2% / 0.005%	**3.5mL**		❑ Patient has trouble with multiple bottle regimen. ❑ Other: _____	❑ BID ❑ QD	
❑ Atropine Sulfate Select only one concentration: ❑ 0.01% ❑ 0.025% ❑ 0.05%	**3.5mL**		❑ Other: _____		

SIG: _____ Total Prescriptions Ordered: _____

For professional use only. OSRX specializes in customizing medications to meet unique patient and practitioner needs. OSRX dispenses these formulations only to individually identified patients with valid prescriptions. No compounded medication is reviewed by the FDA for safety or efficacy. OSRX does not compound copies of commercially available products. References available upon request.

Prescribing Physician Verification

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

Prescriber Full Name: _____ Phone: _____ Fax: _____

NPI: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Business/Clinic Name: _____ Office Contact: _____ Email: _____

Prescriber Signature: _____ Date: _____

Payment Information

Payor: ❑ Doctor ❑ Facility ❑ Patient

Method of Payment:

❑ New Credit Card Number: _____ Expiration: _____ CVC/Code: _____ Billing Zip: _____ ❑ Keep on File

❑ Credit Card on File Ending In: _____ CVC/Code: _____ ❑ Invoice me using my PREAPPROVED terms