



Combination Therapy Drops

ORDER FORM

Fax: 866-515-0196

PROMO CODE: _____

Patient: _____ DOB: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: _____ Allergies: _____ ☐ No Known Allergies

Email: _____

☐ **Auto Refill Program:** By signing here I am requesting to have automatic refills shipped to me monthly

Patient Signature: _____

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| Timolol 0.5% Bimatoprost 0.01% Ophthalmic Solution Drops 5mL 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 0.1% Dorzolamide 2% Ophthalmic Solution Drops 5mL 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 0.1% Dorzolamide 2% Bimatoprost 0.01% Ophthalmic Solution Drops 5mL 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: | Brimonidine 0.1% Dorzolamide 2% Ophthalmic Solution Drops 5mL 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: | Bimatoprost 0.01% Brimonidine 0.1% Dorzolamide 2% Ophthalmic Solution Drops 5mL 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: | Bimatoprost 0.01% Dorzolamide 2% Timolol 0.5% Ophthalmic Solution Drops 5mL 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: |
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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 records 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: _____ Date: _____

*For professional use only. OSRX specializes in customizing compounded medications to meet unique patient needs. Compounded drugs are not FDA-approved, which means they have not undergone FDA premarket review for safety, effectiveness, and quality. **View potential adverse events and contraindications at: www.osrxpharmaceuticals.com/osrx-api-aecontraindication**
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.