OSRX

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: ____________________

Timolol 0.5% **Bimatoprost 0.01%**	**Timolol 0.5%** **Brimonidine 0.1%** **Dorzolamide 2%**	**Timolol 0.5%** **Brimonidine 0.1%** **Dorzolamide 2%** **Bimatoprost 0.01%**	**Brimonidine 0.1%** **Dorzolamide 2%**	**Bimatoprost 0.01%** **Brimonidine 0.1%** **Dorzolamide 2%**	**Bimatoprost 0.01%** **Dorzolamide 2%** **Timolol 0.5%**
Ophthalmic Solution Drops 5mL bottle # of Bottles: _______ Refills: _________	Ophthalmic Solution Drops 5mL bottle # of Bottles: _______ Refills: _________	Ophthalmic Solution Drops 5mL bottle # of Bottles: _______ Refills: _________	Ophthalmic Solution Drops 5mL bottle # of Bottles: _______ Refills: _________	Ophthalmic Solution Drops 5mL bottle # of Bottles: _______ Refills: _________	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:	**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:	**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:	**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:	**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:	**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:

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**