Atropine+
ORDER FORM

Fax: 866-515-0196

PROMO CODE: _____

Patient: _____ DOB: _____ Gender: ☐ M ☐ F 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

Parent/Guardian Signature: _____

SELECT ONLY ONE CONCENTRATION BELOW

☐ **Atropine 0.01%**	☐ No commercially available or FDA-approved product with low-dose atropine and lubricant. Patient benefits from formulation with lubricant. ☐ Other: _____
☐ **Atropine 0.025%**	☐ No commercially available or FDA-approved product with formulation strength that is clinically best for patient. ☐ Other: _____
☐ **Atropine 0.05%**	☐ No commercially available or FDA-approved product with formulation strength that is clinically best for patient. ☐ Other: _____

Ophthalmic Solution Drops (3.5mL bottle) **Directions:** Instill 1 drop in OS / OD / OU eye(s) at bedtime **(Please circle one)**

# of Bottles: _____ Refills: _____ OR: _____

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

For refills, patient is required to call pharmacy: (855)-466-1076. Patients reserve the right to receive medications from a pharmacy of their choice. I have reviewed my patient's 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**