MEDS *IN* MOTION
PHARMACY REFORMULATED

fax form to:
801.590.7003

BAK Free Dorzolamide/Timolol

PATIENT

Patient Name: ____________________

Phone: ____________ D.O.B: ________

Address: ____________________

Allergies: ____________________

PROVIDER

Provider Name: ____________________

Phone: ____________________

Contact Name: ____________________

Contact Email: ____________________

NPI: ____________________

PRESCRIPTION

Dorzolamide/Timolol 2%/0.5% BAK Free Ophthalmic, 6mL

Refills: ___ 6 PRN

____________ Date

____________________ Signature

Directions: Instill one drop into each affected eye twice daily.

For patient security
Please print and fax form to:

801.590.7003

Questions?

855.506.6999
medsinmotion.com