DERMATOLOGY



FAX: 212.889.0033 PHONE: 212.889.0022

Patient Information			Prescriber Information	
Patient name: DOB:			Prescriber name:	
Sex: ☐ Female ☐ Male Last 4 of SSN:			DEA:	
Language:			NPI:	
			Group/Hospital:	
Address:			Address:	
Apt/Suite: City:	State: Z	Zip:		
Phone:	Alternate:	· · · · · · · · · · · · · · · · · · ·		State: Zip:
Email Address:			Phone:	_ Fax:
Please fax a copy of front and back of the insurance card(s).			Contact Person:	Phone:
Clinical Information (Please i	nclude diagnosis nan	ne with ICD	0-10 code)	
☐ L70.0 Acne vulgaris			Date of Diagnosis	
☐ L20.9 Atopic dermatitis, unspecified			Tried and failed medications	
☐ L40.9 Psoriasis, unspecified				
☐ B35.1 Onychomycosis, Tinea Unguid	um			
□ Other: ICD-10 Code			Additional notes	
Description				
Medication	Dose/Quantity Ref	fills SIC	3	
□ Product substitution permitted □ Dispense as written				
Prescriber's Signature*:Date:				
Prescriber's Signature*:				Date:

*l authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.