



FAX: 609.829.0021 PHONE: 609.829.0020

Patient Information Prescriber Information Prescriber name: _____ Patient name: _____ DOB: ____ Sex: ☐ Female ☐ Male Last 4 of SSN: Language: Group/Hospital: Address: Apt/Suite: _____ City: _____ State: ____ Zip: ____ Apt/Suite: _____ City: _____ State: ____ Zip: _____ Alternate: Phone: ___ Phone:_____ Fax: _____ Email Address: Contact Person: _____ Phone: _____ Please fax a copy of front and back of the insurance card(s). Clinical Information (Please include diagnosis name with ICD-10 code) Date of Diagnosis_ ☐ L70.0 Acne vulgaris ☐ L20.9 Atopic dermatitis, unspecified Tried and failed medications ☐ L40.9 Psoriasis, unspecified ☐ B35.1 Onychomycosis, Tinea Unguium Additional notes ☐ Other: ICD-10 Code Description Dose/Quantity Refills SIG Medication ☐ Product substitution permitted ☐ Dispense as written Prescriber's Signature*: 1 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.