

Patient Information	Prescriber Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Last 4 of SSN: _____ Language: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Email Address: _____	Prescriber name: _____ DEA: _____ NPI: _____ Group/Hospital: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Contact Person: _____ Phone: _____
<b>Please fax a copy of front and back of the insurance card(s).</b>	

Clinical Information (Please include diagnosis name with ICD-10 code)	
<input type="checkbox"/> L70.0 Acne vulgaris <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified <input type="checkbox"/> L40.9 Psoriasis, unspecified <input type="checkbox"/> B35.1 Onychomycosis, Tinea Unguium <input type="checkbox"/> Other: ICD-10 Code _____ Description _____	Date of Diagnosis _____ Tried and failed medications _____ Additional notes _____

Medication	Dose/Quantity	Refills	SIG

Product substitution permitted     Dispense as written

Prescriber's Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

\*I 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.