# DERMATOLOGY

APOTHECO PHARMACY
WESTPORT APOTHECARY

FAX: 203.226.8889
PHONE: 203.226.8888

## Patient Information

Patient name: _____ DOB: _____

Sex: ☐ Female ☐ Male Last 4 of SSN: _____

Language: _____

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

Email Address:_____

**Please fax a copy of front and back of the insurance card(s).**

## Prescriber Information

Prescriber name: _____

DEA: _____

NPI: _____

Group/Hospital: _____

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Phone:_____ Fax: _____

Contact Person: _____ Phone: _____

## Clinical Information (Please include diagnosis name with ICD-10 code)

☐ L70.0 Acne vulgaris

☐ L20.9 Atopic dermatitis, unspecified

☐ L40.9 Psoriasis, unspecified

☐ B35.1 Onychomycosis, Tinea Unguium

☐ 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.