DERMATOLOGY

APOTHECO PHARMACY
PENN MEDICAL

FAX: 215.960.9011
PHONE: 215.960.9010

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.