

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

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.