



FAX: 312.392.5801

PHONE: 312.392.5801

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