

PATIENT INFORMATION

Rx for in-office use only

Patient Name _____ DOB _____ Phone _____

Address _____ City, State _____ Zip _____

Applicable Diagnosis Codes/Descriptions: _____

PLEASE FAX COPY OF FACE SHEET, IF AVAILABLE

PRESCRIPTION INFORMATION

ANTI-FUNGAL:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Ala-Quin Cream | <input type="checkbox"/> Ecoza Foam | <input type="checkbox"/> Miconazole 2% cream | <input type="checkbox"/> Terbinafine 1% cream |
| <input type="checkbox"/> Clotrimazole 1% cream | <input type="checkbox"/> Kerydin Solution | <input type="checkbox"/> Naftin Cream | <input type="checkbox"/> Tolnaftate 1% cream |
| <input type="checkbox"/> Ciclodan cream | <input type="checkbox"/> Luzu Cream | <input type="checkbox"/> Nystatin Powder | <input type="checkbox"/> Tolnaftate 1% powder |
| <input type="checkbox"/> Econazole 1% cream | <input type="checkbox"/> MetroGel/Cream | <input type="checkbox"/> Nystatin 100M cream/oint | <input type="checkbox"/> Xolegel Gel |
| <input type="checkbox"/> Ecoza 1% Foam | | | |

Quantity: _____ Refill: _____ Directions: _____

ECZEMA

& RASH:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Clobex Spray | <input type="checkbox"/> EpiCeram Emulsion | <input type="checkbox"/> Hydro 35 Foam | <input type="checkbox"/> Trianex 0.05% Oint |
| <input type="checkbox"/> Cordran Cream/Lotion/Oint | <input type="checkbox"/> Kenalog Spray | <input type="checkbox"/> DrySol Solution | <input type="checkbox"/> Topicort Spray |
| <input type="checkbox"/> Dermasorb AF/HC/TA | <input type="checkbox"/> Nivatopic Plus Cream | <input type="checkbox"/> Topicort (gen) cream/ointment | <input type="checkbox"/> Vanos Cream |

Quantity: _____ Refill: _____ Directions: _____

KERATOSIS & WARTS:

- | | | |
|--|---|--|
| <input type="checkbox"/> Carac 0.5% Cream | <input type="checkbox"/> Imiquimod 5% cream | <input type="checkbox"/> Salicylic Acid 28.5% Solution |
| <input type="checkbox"/> Fluoroplex 1% Cream | <input type="checkbox"/> Picato 0.015% Gel | <input type="checkbox"/> Zyclara 2.5% or 3.75% Cream |

Quantity: _____ Refill: _____ Directions: _____

NAIL CARE:

- | | | |
|--|---|---|
| <input type="checkbox"/> Ciclodan Solution | <input type="checkbox"/> Jubila Solution | <input type="checkbox"/> Umecta 40% Nail Solution |
| <input type="checkbox"/> Genadur Nail Kit | <input type="checkbox"/> Nuvail Nail Solution | <input type="checkbox"/> Uramaxin 45% Nail Gel |

Quantity: _____ Refill: _____ Directions: _____

WOUND CARE, PAIN AND INFLAMMATION:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alevicyn Gel | <input type="checkbox"/> Dakin's Solution .125/.25/.5% | <input type="checkbox"/> Iodosorb Gel | <input type="checkbox"/> Voltaren 2% Gel |
| <input type="checkbox"/> Alevicyn Spray | <input type="checkbox"/> Domeboro Packets | <input type="checkbox"/> Pennsaid 2% Solution | <input type="checkbox"/> Recedo |
| <input type="checkbox"/> Alevicyn SG | <input type="checkbox"/> Intrasite Gel | <input type="checkbox"/> Solaraze 3% Gel | <input type="checkbox"/> Neosalus Cream/Foam/Lotion |

Quantity: _____ Refill: _____ Directions: _____

OTHER ORAL, TOPICAL or COMPOUNDED FORMULA:

Drug or Formula: _____

Quantity: _____ Refills: _____ Directions: _____

Drug or Formula: _____

Quantity: _____ Refills: _____ Directions: _____

PLEASE FAX COPY OF FRONT AND BACK OF ALL INSURANCE CARDS

PRESCRIBING PHYSICIAN

Rx for in-office use only

Physician Name _____ Phone _____ Fax _____

NPI/DEA# _____ Date _____

Physician Signature

****By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent when handling prior authorizations and other medical and prescription insurance forms and communications****