☒ **Urgent** ☒ **Reply ASAP**

| | |
|---|---|
| To: | From: |
| RE Patient: | Date: |
| Phone Number: | Sender's Phone Number: |
| Fax Number: | Sender's Fax Number: |

## Pages Including Cover: 2

**---Patient Information Sheet---**
**PLEASE COMPLETE AND FAX BACK ASAP TO:**

**Date of Last Visit:** _____

**Reason for Visit:** _____

_____

**Allergies:** _____

_____

**Current Medications:** _____

_____

_____

**Affected Area:** _____

_____

Please remember to circle quantity and refill amount for the attached RX your patient has requested from our company.

**PAT ID #:**

Prescription Request

Fax:

Date:

Refills RequestedAuthorized: 3

We request authorization on behalf of your patient

DOB:

Phone:

Please fax or call this request to:

Fax:

Patient:

**INFLAMMATION MANAGEMENT**

**Medication:** Diflorasone Diacetate Ointment 0.05%
**Dispense:** 360 gms
**Sig:** Apply 2-3 gms to affected area(s) 3-4 times daily (1gm=1 dime size)

**LOCAL ANESTHETIC**

**Medication:** Lidocaine 2.5% Prilocaine 2.5% Cream
**Dispense:** 360 gms
**Sig:** Apply 2-3 grams to the affected area 3-4 times daily.

**PSORIASIS / SCAR**

**Medication:** Calcipotriene 0.005% Topical Cream
**Dispense:** 300 Grams
**Sig:** Apply 2-3 gm to affected area 3-4 times daily as directed.

**ANTI-FUNGAL**

**Medication**: Econazole 1% Cream
**Dispense**: 340 gms
**Sig**: Apply 3-6 grams to affected area(s) three times daily (1gm = 1 dime size)

Signature: _____ Date: _____

Doctor:

NPI:

Phone: Fax:

Dispense as Written: ☒

Notes: