Fax D/A

Fax to: _____

	Product Description	Unit Size	Directions	Refills
☐	Calcipotriene Cream, 0.005%	120g	Sig: Apply to affected areas of both arms/legs/trunk/back/face (circle all affected areas) – twice daily	3 6 12 ____
☐	Clobetasol Propionate Ointment, 0.05%	60g	Sig: Apply a thin layer to the affected area of both arms/legs/trunk/back/face (circle all affected areas) – twice daily	3 6 12 ____
☐	Fluocinonide Cream USP, 0.1%	120g	Sig: Apply to affected areas of both arms/legs/trunk/back/face (circle all affected areas) – (choose one) O once daily O twice daily	3 6 12 ____
☐	HPR Plus Cream	450g	Sig: Apply to affected area(s) 1 to 3 times daily (Up to 15gm/day)	3 6 12 ____
☐	HPR Plus Emollient Foam	150g	Sig: Apply to affected areas of both arms/legs/trunk/back/face (circle all affected areas) – (choose one) O once daily O twice daily ___150 x 1 ___150 x 2 ___150 x 3	3 6 12 ____
☐	HPR Plus Hydrogel Kit	1 Kit	Sig: Apply thin layer of Hydrogel to affected area(s) daily	3 6 12 ____
☐	Hydrocortisone Butyrate Cream (Lipophilic), 0.1%	60g	Sig: Apply a thin layer to the affected area(s) – (choose one) O once daily O twice daily O three times daily	3 6 12 ____
☐	Oxiconazole Nitrate Cream, 1%	90g	Sig: Apply to affected ares of both arms/legs/trunk/back/face (circle all affected areas) – (choose one) O once daily O twice daily	3 6 12 ____
☐	Salicylic Acid Cream Kit, 6%	1 Kit	Sig: Use daily or as directed by your physician	3 6 12 ____
☐	Tazarotene Cream, 0.1%	60g	Sig: Apply up to 2 pea sized amounts nightly to the skin where lesions appear. Skin should be dry prior to applying.	3 6 12 ____
☐				3 6 12 ____

Ohio Prescribers: Please send one fax form for each product prescribed.

Patient Information:

Name _____ Cell Phone _____ Home Phone _____

Address _____ Sex O M O F Date of Birth _____

Does the patient have a drug allergy? O No O Yes If YES, please list _____

Prescriber Information: (Licensed Prescriber Signature Required to Validate Rx)

Name _____ Office Phone _____ Office Fax _____

Office Address _____ NPI# _____

License Number _____ # of Prescriptions _____

x _____ x _____

Dispense as Written Date Product Substitution Permitted Date