Version W.1 05/14/2019

Fax to: ______________

	Product Description	Unit Size	Directions	Days' Supply	Refills
☐	Adapalene Gel, 0.3%	45g	Sig: Apply 1 to 3 pea-sized amounts to complete – *(circle all affected areas)* face/back/chest – nightly	15 30 ____	3 6 12 ____
☐	Adapalene 0.1%/ Benzoyl Peroxide 2.5% Gel	45g	Sig: Apply a pea-sized amount to affected area(s) once daily after washing	15 30 ____	3 6 12 ____
☐	BenzePrO Foaming Cloths, 6%	60ct	Sig: Wash affected area(s) – *(choose one)* O once daily O twice daily	15 30 ____	3 6 12 ____
☐	Calcipotriene Cream, 0.005%		Sig: Apply to affected area(s) of complete – *(circle all affected areas)* arms/legs/trunk/back/face – twice daily *(choose one)* – Prescribed Quantity: O 60g O 120g	15 30 ____	3 6 12 ____
☐	Clindamycin Phosphate 1%/ Benzoyl Peroxide 5% Gel		Sig: Apply thin layer to affected area(s) of – *(circle all affected areas)* face/back/chest *(choose one)* O once daily O twice daily *(choose one)* – Prescribed Quantity: O 25g O 50g	15 30 ____	3 6 12 ____
☐	Dapsone 5% Gel		Sig: Apply to affected area(s) of – *(circle all affected areas)* face/chest/ back *(choose one)* O once daily O twice daily *(choose one)* – Prescribed Quantity: O 60g O 90g	15 30 ____	3 6 12 ____
☐	Doxycycline Hyclate Immediate Release, USP Tablets – 75mg		Sig: Take 1 tablet by mouth – *(choose one)* O once daily (quantity: 30) O twice daily (quantity: 60)		3 6 12 ____
☐	Doxycycline Hyclate Immediate Release, USP Tables – 150mg (scored)		Sig: Take – *(choose one)* O 1/3 tablet (quantity: 10) O 2/3 tablet (quantity: 20) O 1 tablet (quantity: 30) by mouth once daily Sig: Take – *(choose one)* O 1/3 tablet (quantity: 20) O 2/3 tablet (quantity: 40) by mouth twice daily		3 6 12 ____
☐	Metronidazole Gel USP, 1%	60g	Sig: Apply up to 2 to 4 pea-sized amounts once daily to affected area(s) of – *(circle all affected areas)* face/chest/scalp/ears	15 30 ____	3 6 12 ____
☐	Minocycline Hydrochloride Extended Release Tablet – 45mg	30ct	Sig: Take one tablet by mouth once daily		3 6 12 ____
☐	Minocycline Hydrochloride Extended Release Tablet – 90mg	30ct	Sig: Take one tablet by mouth once daily		3 6 12 ____
☐	Minocycline Hydrochloride Extended Release Tablet – 135mg	30ct	Sig: Take one tablet by mouth once daily		3 6 12 ____
☐	Oxiconazole Nitrate Cream, 1%		Sig: Apply to affected area(s) of complete – *(circle all affected areas)* arms/legs/feet/trunk/back/face – *(choose one)* O once daily O twice daily *(choose one)* – Prescribed Quantity: O 30g O 60g O 90g	15 30 ____	3 6 12 ____
☐	SulfaCleanse 8/4%	16oz	Sig: Wash affected area(s) – *(circle all affected areas)* face/back/chest – *(choose one)* O once daily O twice daily	15 30 ____	3 6 12 ____
☐	Tazarotene Cream, 0.1%		Sig: Apply up to 2 pea-sized amounts nightly to the skin where lesions appear. Skin should be dry prior to applying. *(choose one)* – Prescribed Quantity: O 30g O 60g	15 30 ____	3 6 12 ____
☐				15 30 ____	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 ______________
Product Substitution Permitted Date

X ______________
Dispense as Written Date