Wellness Pharmacy
AND COMPOUNDING CENTER

DERMATOLOGY MEDICATION REQUEST FORM

Phone: 919-964-5656 | Fax: 919-964-5757 | www.wellnessraleigh.com

PATIENT INFORMATION

- ◯ New Patient ◯ Current Patient
- ◯ New RX ◯ Refill
- ◯ Medicare/Medicaid

Primary Caregiver: _____

PACKAGING

- ◯ Wellness Pharmacy Packaging
- ◯ Vials (Childproof ◯ Yes ◯ No)

DELIVERY/PICK-UP OPTIONS

- ◯ Patient's Home ◯ Pharmacy Pickup
- ◯ MD's Office
- ◯ 1st dose at MD's office and remaining refills at patient's home

Date Required: _____

PATIENT INFORMATION

Last Name, First Name _____ Primary Language _____

Primary Phone Number _____ Alternate Phone Number _____

Home Address _____ City, State _____ Zip _____

Shipping Address (if different from home address) _____

Social Security Number _____ Date of Birth _____

Height _____ Weight _____ BMI _____ Gender ◯ M ◯ F Pregnant ◯ Yes ◯ No

PRESCRIBER INFORMATION

Today's Date _____

Physician Name _____ NPI # _____

State Licence # _____ DEA # _____

Address _____ City, State _____ Zip _____

Phone Number _____ Fax Number _____

Key Office Contact Name _____ Email _____

CLINICAL INFORMATION | PLEASE FAX LABS, CURRENT PRESCRIPTION MEDICATIONS/OTC PROFILE AND HISTORY

Diagnosis _____

Dispense as written _____

PRESCRIPTION INFORMATION OR ATTACH RX

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Acne (Oral)	☐ Doryx	☐ 150mg Tablets		
	☐ Monodox	☐ 75mg Capsules ☐ 10mg Capsules		
	☐ Solodyn	☐ 55 mg Tablets ☐ 65 mg Tablets ☐ 80 mg Tablets ☐ 105 mg Tablets ☐ 115 mg Tablets		
	Other			
	SIG			
Acne (Topical)	☐ Acanya Gel			
	☐ Aczone Gel			
	☐ Atralin Gel			
	☐ Azelex Cream			
	☐ Benz E Foam			
	☐ Benzacilin Pump Care Kit			
	☐ Clindacin PAC/P			
	☐ Differin Gel/Lot/Cr			
	☐ Duac CS Kit			
	☐ Epiduo Ge			
	☐ Evoclin Foam			
	☐ NeoBenz Micro/ Plus Pack			
	☐ Pacnex HP/LP			
	☐ Retin-A Micro			
	☐ Tazorac			
	☐ Triaz Foam Cloths			
	☐ Veltin Gel			
	☐ Ziana Gel			
	Other			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Barrier Preparations	☐ Epiceram			
	☐ Hydo 40 Foam			
	☐ Hylatopic Plus			
	☐ Tetrix Cream			
	☐ Uramaxin Foam			
	Other			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Rosacea	☐ Finacea Gel			
	☐ Metrogel Gel			
	☐ Oracea 40mg Tabs			
	☐ Sumaxin TS			
	Other			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Steroids	☐ Cordran Cream/Lotion			
	☐ Cutivate Lotion			
	☐ Desonate Gel			
	☐ Locoid Lipocream/Lotion			
	☐ Luxiq Foam			
	☐ NeoSalus Foam			
	☐ Olux-E Foam			
	☐ Vanos Cream			
	☐ Verdeso Foam			
	Other			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Rosacea	☐ Clobex			
	☐ Salvax Foam			
	☐ Scytera Foam			
	☐ Tactonex Ointment/Scalp			
	☐ Vertical Ointment			
	Other:			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Miscellaneous	☐ Altabax Ointment			
	☐ Centany Ointment/AT			
	☐ Salkera Foam			
	☐ Uramaxin GT			
	Other			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Actinic Keratosis	☐ Carac Cream			
	☐ Solaraze Gel			
	☐ Zyclara Cream			
	Other			
	SIG			

	MEDICATION	DOSAGE/STRENGTH	QUANTITY	REFILLS
Anti-Fungal	☐ Extina Foam			
	☐ Loprox Shampoo			
	☐ Naftin Cream/Gel			
	☐ Oxistat Cream/Lotion			
	☐ Tersi Foam			
	☐ Vusion Ointment			
	☐ Xologel Gel			
	Other			
	SIG			

I hereby authorize **Wellness Pharmacy and Compounding Center** and its representatives to act as a prior authorization designated agent. I authorize them to deal with medical and prescription insurance companies and to organize/receive patient lab values.

☐ Patient is interested in Patient Support Programs as necessary/applicable

Ancillary kits and supplies provided as necessary/applicable

Doctor/Prescriber Name – Dispense as Written

Date

Doctor/Prescriber Name – Substitution Permissible

Date