



# Prescription Enrollment Form

Fax: 909-284-9140

Phone: 909-266-0016

Urgent Request

Rep: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Gender \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name \_\_\_\_\_  
 DEA \_\_\_\_\_  
 NPI \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Absorica LD	<input type="checkbox"/> 8mg <input type="checkbox"/> 16mg <input type="checkbox"/> 24mg <input type="checkbox"/> 32mg	<input type="checkbox"/> Take 1 capsule by mouth once daily <input type="checkbox"/> Take 1 capsule by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Capsules <input type="checkbox"/> 60 Capsules <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Accutane	<input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take 1 capsule by mouth once daily <input type="checkbox"/> Take 1 capsule by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Capsules <input type="checkbox"/> 60 Capsules <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Claravis	<input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take 1 capsule by mouth once daily <input type="checkbox"/> Take 1 capsule by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Capsules <input type="checkbox"/> 60 Capsules <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Myorisan	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take 1 capsule by mouth once daily <input type="checkbox"/> Take 1 capsule by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Capsules <input type="checkbox"/> 60 Capsules <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Minolira ER	<input type="checkbox"/> 105mg <input type="checkbox"/> 135mg	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 60 Tablets <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Seysara	<input type="checkbox"/> 60mg <input type="checkbox"/> 100mg <input type="checkbox"/> 150mg	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 60 Tablets <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Ximino ER (Minocycline ER)	<input type="checkbox"/> 45mg <input type="checkbox"/> 90mg <input type="checkbox"/> 135mg	<input type="checkbox"/> Take 1 capsule by mouth once daily <input type="checkbox"/> Take 1 capsule by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 Capsules <input type="checkbox"/> 60 Capsules <input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Other				<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____

Ship to:  Patient  Office  Other \_\_\_\_\_ Date: \_\_\_\_\_ Need by Date \_\_\_\_\_

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted  Dispense as Written

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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