WHOLE HEALTH PHARMACY

Prescription Enrollment Form

Fax: 949-340-8008
Phone: 949-305-0788
□ **Urgent Request**
Rep: Andrew

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
☐ **Absorica LD**	☐ 8mg ☐ 16mg ☐ 24mg ☐ 32mg	☐Take 1 capsule by mouth once daily ☐Take 1 capsule by mouth twice daily ☐_____	☐30 Capsules ☐60 Capsules ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
☐ **Accutane**	☐ 20mg ☐ 30mg ☐ 40mg	☐Take 1 capsule by mouth once daily ☐Take 1 capsule by mouth twice daily ☐_____	☐30 Capsules ☐60 Capsules ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
☐ **Claravis**	☐ 20mg ☐ 30mg ☐ 40mg	☐Take 1 capsule by mouth once daily ☐Take 1 capsule by mouth twice daily ☐_____	☐30 Capsules ☐60 Capsules ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
☐ **Myorisan**	☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg	☐Take 1 capsule by mouth once daily ☐Take 1 capsule by mouth twice daily ☐_____	☐30 Capsules ☐60 Capsules ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
☐ **Minolira ER**	☐ 105mg ☐ 135mg	☐Take 1 tablet by mouth once daily ☐Take 1 tablet by mouth twice daily ☐_____	☐30 Tablets ☐60 Tablets ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
☐ **Seysara**	☐ 60mg ☐ 100mg ☐ 150mg	☐Take 1 tablet by mouth once daily ☐Take 1 tablet by mouth twice daily ☐_____	☐30 Tablets ☐60 Tablets ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
☐ **Ximino ER** (Minocycline ER)	☐ 45mg ☐ 90mg ☐ 135mg	☐Take 1 capsule by mouth once daily ☐Take 1 capsule by mouth twice daily ☐_____	☐30 Capsules ☐60 Capsules ☐_____	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____
□ **Other**				☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ _____

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: _____