Whole Health Pharmacy

Topical Enrollment Form

Fax: 949-340-8008
Phone: 949-305-0788

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name ____
Address ____
Address 2 ____
City, State, Zip ____
Home Phone ______________ Mobile Phone ______________
DOB __________Last Four of SS __________ Gender _____
Language Preference ________________________________

PRESCRIBER INFORMATION

Prescriber Name ____
DEA ____
NPI ____
Address ____
City, State, Zip ____
Phone ________________ Fax ________________________
Contact Person ________________________________

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ **Aklief**	□ 0.005% Cream	□ Apply a thin layer to affected areas once daily in the evening	□ 45gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Arazlo**	□ 0.045% Lotion	□ Apply 1 application to affected area(s) 2 times daily	□ 45gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Betamethasone**	□ 0.05% Cream	□ Apply 1 application to affected area(s) 2 times daily □ Apply 1 application to affected area(s) once a day as needed	□ 45gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Calcipotriene**	□ 0.005% Cream □ 0.005% Ointment	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm □ 120gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Clobetasol**	□ 0.05% Cream	□ Apply 1 application to affected area(s) 2 times daily □ Apply 1 application to affected area(s) once a day as needed	□ 45gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Duobrii**	□ 0.01%/0.045% Lotion	□ Apply 1 application to affected area(s) once a day	□ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Elidel**	□ 1% Cream	□ Apply 1 application to affected area(s) 2 times daily	□ 30gm □ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Enstilar**	□ 0.005%/0.064% Foam	□ Apply 1 application to affected area(s) once a day	□ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Epiduo Forte**	□ 0.3%/2.5% gel	□ Apply 1 application to affected area(s) once a day	□ 45gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Exelderm**	□ 1% Solution □ 1% Cream	□ Apply 1 application to affected area(s) once a day	□ 30ml □ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Eucrisa**	□ 2% Ointment	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Fabior**	□ 0.1% Foam	□ Apply 1 application to affected area(s) once a day in the evening	□ 50gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Finacea**	□ 15% Foam	□ Apply 1 application to affected area(s) 2 times daily	□ 50gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Fluocinonide**	□ 0.05% Solution	□ Apply 1 application to affected area(s) once a day as needed	□ 60ml	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Fluocinolone**	□ 0.01% Solution	□ Apply 1 application to affected area(s) once a day as needed	□ 60ml	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Protopic**	□ 0.03% Ointment □ 0.1% Ointment	□ Apply 1 application to affected area(s) 2 times daily	□ 30gm □ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Opzelura**	□ 1.5% Cream	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Retin-A Micro**	□ 0.06% Gel Pump	□ Apply 1 application to affected area(s) once a day in the evening	□ 50gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Rhofade**	□ 1% Cream	□ Apply 1 application to affected area once daily	□ 30gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Soolantra**	□ 1% Cream	□ Apply 1 application to affected area once daily	□ 30gm □ 45gm □ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Sorilux**	□ 0.005% Foam	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Tazorac**	□ 0.1% Gel	□ Apply 1 application to affected area(s) 2 times daily	□ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Winlevi**	□ 1% Cream	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Wynzora**	□ 0.005%/0.0064% Cream	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ______
□ **Other**				

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: ________________________

CONFIDENTIALITY STATEMENT: This communication is intended for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.