DERM COMPOUNDING ENROLLMENT FORM

Fax to: 430-200-5425

24 Wellness Rx

DATE: _____ DATE NEEDED: _____ **SHIP TO:** ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
3320 Troup Highway, Suite 140
Tyler, TX 75701
Phone: 903-266-1975
Toll Free: 833-682-3515

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐ MALE ☐ FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

CLINICAL INFORMATION

DATE OF DIAGNOSIS: _____ ALLERGIES: _____

DIAGNOSIS CODE: _____ OTHER: _____

PRESCRIPTION INFORMATION

	Dose/Form / Strength	Sig	Refills
WARTS			
☐ Cantharidin 10ml	☐ 0.7% Solution	Sig: Bring to office for procedure _____	
☐ Cantharidin 10ml	☐ Plus Solution	Sig: Bring to office for procedure _____	
☐ Salicylic Acid Topical Paste 30gm	☐ 60% ☐ 80%	Sig: _____	
NAIL FUNGUS			
☐ Fluconazole 15ml	☐ 2% Ibuprofen 2% Nail Solution	Sig: Apply once daily to affected toe nail(s) _____	
COLD SORES/SHINGLES			
☐ Acyclovir/Lidocaine 5gm	☐ 5/1% Lip Balm	Sig: Apply 5 times daily to lesions _____	
☐ Acyclovir/Lidocaine 30gm	☐ 5/1% Topical Ointment	Sig: Apply ____ times daily to affected area(s) _____	
HYPERPIGMENTATION Bleaching/ Skin Lightening Cream	**Dose/Form / Strength**	**Sig**	
☐ Hydroquinone Topical Cream 30gm	☐ 5% ☐ 6% ☐ 8% ☐ 10%	Sig: _____	
☐ Hydroquinone/Glycolic Acid 30gm	Topical Cream ☐ 5/5% ☐ 5/2%	Sig: _____	
☐ Hydroquinone/Kojic Acid 30gm	Topical Cream ☐ 2/8% ☐ 4/4% ☐ 6/4% ☐ 8/4%	Sig: _____	
☐ Hydroquinone/Glycolic Acid /Tretinoin/Hydrocortisone 30gm	Topical Cream 8/4/0.05/0.5%	Sig: _____	
☐ Tretinoin/triamcinolone /hydroquinone Topical Cream 30gm	☐ 0.5/0.05/5% ☐ 0.1/0.1/5%	Sig: _____	
☐ Blackburn Cream 60gm		Sig: _____	
ACNE	**Dose/Form / Strength**	**Sig**	**Refills**
☐ Hyrocortisone 1% in Sulfacetamide 10% Lotion 30ml		Sig: _____	
☐ Hydrocortisone .05% in Sulfacetamide 10% Lotion 30ml		Sig: _____	
☐ Niacinamide 30gm	4% Topical Cream	Sig: _____	
☐ Tetracycline Hydrchloride 30ml	2.25mg/ml topical solution	Sig: _____	
☐ Clindamycin 1% in Betamethasone Valerate 0.1% Topical Solution 60ml	Sig:		
ECZEMA	**Dose/Form / Strength**	**Sig**	**Refills**
☐ Cyanocobalamin 60gm	☐ 0.07% Topical Creamn	Sig: _____	
LOCAL ANESTHETIC TOPICAL	**Dose/Form / Strength**	**Sig**	**Refills**
☐ Benzocaine/Lidocaine/Tetracaine 20/6/4% Plasticized Ointment	☐ 30gm ☐ 60gm ☐ 120gm	Sig: _____	
☐ Benzocaine/Lidocaine/Tetracaine 20/6/4% Emollient Cream	☐ 30gm ☐ 60gm	Sig: _____	
☐ Benzocaine/Lidocaine/Tetracaine 20/8/6% Emollient Cream	☐ 30gm ☐ 60gm	Sig: _____	
☐ Tetracaine/Lidocaine 23/7% Ointment (plasterided)	☐ 30gm ☐ 60gm ☐ 120gm	Sig: _____	

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____

Telephone: _____ Fax: _____ Email: _____

Office Address: _____ City: _____ State: _____ Zip: _____

NPI # : _____ DEA # : _____ TAX ID # : _____ Medicaid Provider # : _____

_____ _____ * _____

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.