

LINCOLN PHARMACY

831 STERLING PARKWAY, SUITE #120, LINCOLN, CA 95648
PHONE: 916-209-3618 | FAX: 916-209-3634 | www.yourlincolnpharmacy.com

Date: _____

DERMATOLOGY PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ Male Female
Address: _____ Date of Birth: _____
City, State, Zip: _____ SSN: _____
Phone: _____

Need by Date: _____
Ship to: Patient Home
 Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: _____ Date of Diagnosis/ Years with disease: _____ Try and Fail medications: _____
Weight: _____ lbs / kg Height: _____ Allergies: _____ %BSA affected _____ TB Test: _____

PRESCRIPTION INFORMATION

INITIAL PRESCRIPTION

PREVIOUSLY DISPENSED

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml PFS <input type="checkbox"/> 25mg/ml PFS <input type="checkbox"/> Other:	<input type="checkbox"/> Inject 50mg SC Twice a week for 3 months <input type="checkbox"/> Inject 50mg SC once a week <input type="checkbox"/> Other:		
<input type="checkbox"/> Humira®	<input type="checkbox"/> 20mg/0.4ml PFS (2 doses) <input type="checkbox"/> 40mg/0.4ml PFS (2 doses) <input type="checkbox"/> Other:	<input type="checkbox"/> Inject two 40mg SC day 1; then 40mg SC day 8; then 40mg SC every other week <input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Other:		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml Auto-injector <input type="checkbox"/> 50mg/0.5ml PFS	<input type="checkbox"/> Inject 50mg SC once a month		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5ml PFS <input type="checkbox"/> 90mg/1ml PFS	<input type="checkbox"/> Patient<100kg: Inject 45mg SC at day 1; then 45mg SC day 30 and then every 12 weeks <input type="checkbox"/> Patient>100kg: Inject 90mg SC at day 1; then 90mg SC day 30 and then every 12 weeks <input type="checkbox"/> Other:		
<input type="checkbox"/> Oxsoralen-Ultra®	<input type="checkbox"/> 10mg			

Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ Date: _____ Do not substitute

Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ Date: _____

Important Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.