Patient Information | ***Date:*** ____/____/____

Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____-_____-_____ E-Mail: _____

Prescriber Name, Address & Phone Number:

Medication	Strength	Directions	Quantity	Refills
☐ **Humira Starter Kit (6 Pens)**	40mg/0.8mL	Inject 160mg (4 pens) for the initial Dose **THEN** 2 weeks later (on day 15) inject 80mg (2 pens)		☐ PRN ☐ Other:_____
☐ **Humira Maintenance Pens (2 Pens)**	40mg/0.8mL	Inject 40mg (1 pen) every other week		☐ PRN ☐ Other:_____
☐ **Stelara**	☐ 45mg/0.5mL ☐ 90mg/1mL	☐ 45 mg SQ initially and 4 weeks later, followed by 45 mg SQ every 12 weeks **OR** ☐ 90 mg SQ initially and 4 weeks later, followed by 90 mg SQ every 12 weeks		☐ PRN ☐ Other:_____
☐ **Compounded Hydroquinone Cream**	☐ 4% ☐ 6% ☐ 8% ☐ ___%			☐ PRN ☐ Other:_____
☐ **Compounded Benzocaine/Lidocaine/Tetracaine Cream**	☐ 20%/10%/4% ☐ ___%/___%/___%			☐ PRN ☐ Other:_____
☐ **Compounded Azelaic Acid/Niacinamide Cream**	☐ 15%/5% ☐ _____%/_____%	Apply a pea sized amount to_____ every_____ If necessary, repeat _____times a _____		☐ PRN ☐ Other:_____
☐ **Compounded Niacinamide/Tretinoin Cream**	☐ 2%/0.05% ☐ _____%/_____%	Apply a pea sized amount to_____ every_____ If necessary, repeat _____times a _____		☐ PRN ☐ Other:_____
Tretinoin ☐ **Cream** ☐ **Gel**	☐ _____%	Apply a pea sized amount to_____ every_____ If necessary, repeat _____times a _____		☐ PRN ☐ Other:_____
Tretinoin Micro ☐ **Cream** ☐ **Gel**	☐ _____%	Apply a pea sized amount to_____ every_____ If necessary, repeat _____times a _____		☐ PRN ☐ Other:_____

Total # of Prescriptions:_____

Prescriber Signature:

_____ Dispense As Written

_____ Substitution Permissible