

DERMATOLOGY FORMULA REFERENCE FORM

PATIENT NAME _____ DATE OF BIRTH _____ SEX _____

PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____
NO P.O. BOX- STREET ADDRESS ONLY

PHONE NUMBER _____ ALTERNATE PHONE _____ EMAIL _____

ALLERGIES _____ SCAR TYPE OR DESCRIPTION _____

ACNE (MILD TO MODERATE)

- AZELAIC ACID 20% / NIACINAMIDE 5% CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA 1-2 TIMES DAILY AS TOLERATED
- CLINDAMYCIN 1% / BENZOYL PEROXIDE 5% / NIACINAMIDE 4% IN CLARIFYING CREAM
30GM - APPLY TO AFFECTED AREA 1-2 TIMES DAILY TO CLEAN, DRY SKIN
- CLINDAMYCIN 1% / TRETINOIN 0.025% IN CLARIFYING CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA AT BEDTIME. WEAR SUNBLOCK DURING THE DAY

ANTI-AGING (MENOPAUSEL SKIN / DERMAL ATROPHY)

- E3 (ESTRIOL) 0.2% IN PRACASIL CREAM
30GM - APPLY SPARINGLY TO FACE AND NECK ONCE DAILY
- HYDROQUINONE 4% / TRETINOIN 0.05% / FLUOCINOLONE 0.01% IN PRACASIL CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA AT BEDTIME. WEAR SUNBLOCK DURING THE DAY

ANTI-AGING PREVENTION (PERI-MENOPAUSEL SKIN / MILD CHANGE)

- HYDROQUINONE 4% / TRETINOIN 0.05% / FLUOCINOLONE 0.01% IN PRACASIL CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA AT BEDTIME. WEAR SUNBLOCK DURING THE DAY

OTHER FORMULATIONS

- ROSCACEA (MILD TO MODERATE)**
- AZELAIC ACID 20% / NIACINAMIDE 4% IN CLARIFYING CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA 1-2 TIMES DAILY AS TOLERATED
- ECZEMA / PSORIASIS**
- CLOBETASOL PROPIONATE 0.05% / LCD 5% / SALICYLIC ACID 6% IN XEMATOP CREAM
30GM - APPLY TO THE AFFECTED AREA TWICE DAILY FOR UP TO 3 WEEKS. ORDER WITHOUT STERIOD FOR LONG TERM USE
- DRY FACIAL SKIN**
- VITAMIN E 0.5% IN PRACASIL CREAM
30GM - APPLY TO AFFECTED AREA 2-3 TIMES DAILY AS NEEDED
- VAGINAL REJUVENATION/VAGINAL ATROPHY**
- NO CANCER RISKS:**
- ESTRIOL 2GM/GM VAGINAL CREAM
30GM - INSERT 1 GM VAGINALLY AT BEDTIME FOR 14 DAYS, THEN USE 2-3 TIMES WEEKLY THEREAFTER

PROCEDURE SCAR PREVENTION AND DECREASED INFLAMMATION

- SODIUM HYALURONATE 0.5% / TRETINOIN 0.025% / ALOE VERA 0.5% IN PRACASIL CREAM
30GM - APPLY TO AFFECTED AREA 2 TIMES DAILY
- MUPIROCIN 2% / ALOE VERA 0.5% IN PRACASIL CREAM
30GM - APPLY TO AFFECTED AREA 2-3 TIMES DAILY

SIG: _____ **REFILLS REQUESTED:** _____
ALTERNATE SIG: _____ **DISPENSE:** **GM OTHER:** _____ **GM**

ADDITIONAL MEDICATIONS TO ADD: _____
Prescriber Verification:

I have reviewed my patient's medical record and determine the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of the order in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me. I understand that this form is for reference only and does not constitute a legal New York State Prescription

Prescriber Full Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ ST: _____ Zip: _____

NPI #: _____ DEA: _____ Doctor Specialty: _____

Signature: _____ Date: _____ Office Contact: _____