

DERMATOLOGY PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Owl Specialty Pharmacy
 1010 E. Arrow Hwy., Covina, CA 91724
 Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523
www.owlspecialty.com



Patient Information: please provide a copy of the patient's insurance card or information				
Patient Name:	DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:	ID#:	Group #:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:				
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization				
Diagnosis / ICD-10	<input type="checkbox"/> Psoriasis / _____ <input type="checkbox"/> Psoriatic Arthritis / _____ <input type="checkbox"/> Chronic Idiopathic Urticaria / _____ <input type="checkbox"/> Hidradenitis Suppurativa / _____ <input type="checkbox"/> Acne / _____ <input type="checkbox"/> Other: _____			
PSO/PSA	Diagnosed with: <input type="checkbox"/> CHF <input type="checkbox"/> Latex Allergy <input type="checkbox"/> MS <input type="checkbox"/> Hep B/C <input type="checkbox"/> Malignancy		Affected areas: <input type="checkbox"/> palms <input type="checkbox"/> soles <input type="checkbox"/> head <input type="checkbox"/> neck <input type="checkbox"/> genitalia	
	TB/PPD test: Y / N Date of negative test: _____		% of BSA affected: _____	
	<input type="checkbox"/> Patient is currently on therapy (Start date __/__/____) Prior Therapies: Please include biologics, MTX, PUVA, topicals, UVB/NBUVB and trials, including dates of treatment and reasons for discontinuation.			
CIU	Continuation of therapy with Xolair: Y / N (Start date __/__/____)		Patient achieved adequate response to Xolair: Y / N	
	Prior Therapies: Please include H1 antihistamines, leukotriene blockers and combination therapy, including dates of treatment, dose & reason for discontinuation.			
Prescription Information				
Medication	Dose / Strength	Directions	Quantity	Refills
Prescriber Information				
Prescriber name:		Phone:	Office contact name:	
Prescriber address:		City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:		
Prescriber signature:		Date:	<input type="checkbox"/> DO NOT SUBSTITUTE	

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