



Today's Date: _____ Needed by: _____ Name: _____ Phone: _____

Patient Demographic: (Provide the following or attached demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
SS#: _____ Date Birth: _____
Gender: _____ Height: _____ Weight: _____ BSA: _____ m2

Prescriber: (Provide as much information as possible)

Prescriber's Name: _____ Group/Hospital: _____
Specialty: _____ NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Alt. Contact Name: _____
Phone: _____ Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card)

Primary Insurance Name: _____ ID#: _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
 No Insurance Patient will pay out of pocket Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):

Patient Address First Fill Physician's Office, Refill to Patient Address Patient will pick up at Pharmacy

I Pledge Account Number

Diagnosis (ICD-10 code): _____ Allergies: _____

Prior (Failed) Medications (Reason for D/C)

1. _____
2. _____

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Zenatane	10mg 20mg 30mg 40mg	Sig: _____		
<input type="checkbox"/> Trianex	0.05% Ointment	Sig: _____	430 GM	
<input type="checkbox"/> Sernivo	0.05% Spray	Sig: _____	120 ML	
<input type="checkbox"/> Other		Sig: _____		

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature Date: ____/____/____