

Patient Information				Prescriber Information	
Patient Name:		DOB:		Prescriber's Name:	
Address:				NPI#:	
City:	State:	Zip:		DEA#:	License#:
Phone:		Alternate Phone:		SSN:	
Height:	Weight:	Allergies:		Phone:	Fax:
Emergency Contact:		Phone:		Contact Person:	
Is the patient pregnant, planning a pregnancy or nursing:				Yes	No
				Does the patient need interpreter services:	
				Yes	No

Documentation (Required)		
Insurance Card (front and back)	Current Medications	History/Progress Notes

Client Considerations	
Diagnosis (ICD 10):	B08.8 Other specified viral infections characterized by skin and mucous membrane lesions L08.89 Other specified local infections of the skin and subcutaneous tissue L20.8 Other atopic dermatitis: Eczema L20.9 Atopic dermatitis, unspecified Other (please specify): _____

Medication	Dose/Strength	Directions for Use	Qty	Refills
CARAC® CREAM, 0.5% (5% fluorouracil)		Apply once a daily to the skin where actinic keratosis lesions appear.	30gm	
DUPIXENT® (Dupilumab 300mg/2ml)	300mg PFS	Loading Dose: Inject an initial dose of 600mg (2 PFS) in different injections sites. Maintenance Dose: Inject 300mg (1 PFS) every other week.		
EFUDEX® (5% fluorouracil)	2% Solution 5% Solution 5% Cream	Apply cream or solution twice daily in an amount sufficient to cover the lesions.	10ml 25ml 40gm	
EUCRISA® (Crisaborole 2% Ointment)	2% (20mg/gram)	Apply a thin layer of EUCRISA twice daily to affected areas.		
PICATO® (Ingenol Mebutate Gel)	0.015% (face/scalp tx) 0.05% (body tx)	Apply 1 tube per day for 3 consecutive days. Apply 1 tube per day for 2 consecutive days.		
SIVEXTRO® (Tedizolid Phosphate)	200mg IV 200mg Tablet	Once Daily for 6 Days Once Daily for 6 Days		
TREMFYA® (Guselkumab)	100mg PFS	Starting Dose: Inject 100mg SQ at week 0, 4 and every 8 weeks thereafter. Maintenance Dose: Inject 100mg SQ every 8 weeks	One Carton Two Cartons	
ZYVOX® (Linezolid)	600mg IV 600mg Tablet	Twice Daily Twice Daily		

By signing this form I authorize Aleracare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____ Prescriber's Signature	_____ Date
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