

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

AME26-01

PATIENT INFORMATION				
First Name	Last Name	Date of Birth ____ / ____ / ____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip
email		Home Phone	Cell Phone	

PRESCRIBER INFORMATION				
Prescriber Full Name			Prescriber Credential	
Office Address		City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone	
Practice Contact Person		Prescriber NPI	Preferred Contact Method <input type="checkbox"/> email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	

CLINICAL INFORMATION - please include any relevant office visit/lab notes to support this prescription	
Patient is <input type="checkbox"/> Naïve <input type="checkbox"/> Previously Treated	Procedure Date ____ / ____ / ____
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Hypersensitivity to porphyrins <input type="checkbox"/> Drug Allergies (please list)	
Therapies Tried (please check name and include dates)	
<input type="checkbox"/> Fluorouracil (Carac 0.5%, Efudex 5%, Fluoroplex 1%, Tolak 4%) Date ____ / ____ / ____	
<input type="checkbox"/> Imiquimod Cream (Aldara 5%, Zyclara 3.75%, Zyclara Pump 2.5%, 3.75%) Date ____ / ____ / ____	
<input type="checkbox"/> Tirbanibulin (Klisyri) Date ____ / ____ / ____	
<input type="checkbox"/> Diclofenac Gel Date ____ / ____ / ____	
<input type="checkbox"/> Cryosurgery Date ____ / ____ / ____	
<input type="checkbox"/> Other: Date ____ / ____ / ____	
Current Medications (please list name and dose):	<i>Reason for therapeutic failure/therapy not tried</i>
	<input type="checkbox"/> Adverse Reactions (local skin reaction, ocular reaction)
	<input type="checkbox"/> Adherence concerns
	<input type="checkbox"/> Hypersensitivity to aspirin and/or NSAID products
ICD-10 Code <input type="checkbox"/> L57.0 Actinic keratosis	
<input type="checkbox"/> Other: _____	
<i>Indication Demographics:</i>	
Site of Lesion(s): <input type="checkbox"/> Face <input type="checkbox"/> Scalp <input type="checkbox"/> Other _____	

PRESCRIPTION - please check all boxes across row				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> <b>AMELUZ®</b> (aminolevulinic acid HCl)	<input type="checkbox"/> topical gel, 10%	Apply gel to affected area(s) as designated by prescriber prior to procedure. Approved for up to 3 tubes (6 gm) per treatment.	<input type="checkbox"/> 1 tube = 200 units (2 gm) <input type="checkbox"/> 2 tubes = 400 units (4 gm) <input type="checkbox"/> 3 tubes = 600 units (6 gm) <input type="checkbox"/> _____	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

**Prescriber's signature:** \_\_\_\_\_  MD  DO  PA  CRNP **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

*Note: The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION			
Ship to: <input type="checkbox"/> Physician Office (listed above) <input type="checkbox"/> Clinic/Other		Contact Name	Date shipment needed by ____ / ____ / ____
Address		City	State Zip