PERSONAL DERM

exclusively available at Curexa®

Compounded Prescription Patient Enrollment Form

Customer Service: (855) 927-0390
Fax completed form to: (855) 927-0392

Patient Information

Patient Name:

DOB: **Gender:** ☐ M ☐ F

Address:

City:

State: **Zip:**

Phone:

Patient agrees to receive a text message and/or email to complete check out

Email:

Best Time to Contact:

Prescriber Information

Prescriber Name:

NPI:

Prescriber Phone: **Fax:**

Address:

City:

State: **Zip:**

Curexa is a PCAB® and UCAP® Accredited compounding pharmacy.
Important Notice: This form and its contents may contain private and confidential information that is intended for the individual or entity to which it is addressed. This transmission may contain information that is exempt from disclosure under laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unless explicitly stated, you are strictly prohibited from disseminating, copying or distributing any material contained within. Violators will be prosecuted to the fullest extent of the law. If you received this communication in error, please notify us immediately and destroy this form and its contents. The information contained herein is for reference only and is not to be relied upon as making any representation as to the efficacy of any formulations. The sample formulations described herein result from prescriptions previously ordered by professionals licensed to write prescriptions in the respected disciplines. Nothing herein is intended to replace or influence the independent judgement of any licensed professional.

Quality recognized by:

Prescription Information

Please select a suggested prescription medication(s):	*Quantity*
☐ **AM Acne Gel** Contains: Clindamycin Phosphate 1% Directions: Apply a pea size amount to face after washing face each morning.	15g
☐ **PM Acne Gel** Contains: Clindamycin Phosphate 1% and Tretinoin 0.04% Directions: Apply a pea size amount to face after washing face each evening.	15g
☐ **Benzoyl Peroxide 4% Wash** Directions: Lather and rinse with a quarter size amount to the affected area once to twice daily as tolerated.	170g
☐ **Onychomycosis Nail Solution** Contains: Miconazole 2% and Terbinafine 2% Directions: Apply a thin layer of medication to the affected area twice daily	10g
☐ **Personalized Tretinoin _____ Gel** (Strength Between 0.025 to 0.1%) Directions: Apply a pea sized amount to face once daily at bedtime as directed.	15g
☐ **Other:** _____ Directions:	Quantity: ___

Date: **Refills:** 0 1 2 3 4 5 6 PRN *(circle one)*

Allergies (Required):

Provider Signature

A licensed medical practitioner with authorization to prescribe medications must sign below to complete prescription. This signature will be verified upon receipt of prescription referral.
By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that EHT Pharmacy LLC. Dba "Curexa®" reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through the Gentleman's Choice™ program. Finally, I authorize Curexa® as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow Curexa® to contact me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

Prescriber Signature:

_____ _____
Signature *Date*

Auto-Refill Subscription

Auto-Refill Subscription (to be completed by patient)

(Check Here) ☐ Please enroll me in theauto-refill program
(Check Here) ☐ 4 weeks ☐ 6 weeks ☐ 8weeks

Patient Attestation: By checking the box above, I agree to receive regular automatic refills of my medication provided by Curexa® Pharmacy located at 3007 Ocean Heights Ave., Egg Harbor Township, NJ 08234.

Patient Signature:

_____ _____
Signature *Date*

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