Carepoint™
A Pharmacy That Truly Cares

Podiatry Referral Form

www.carepointrx.com
Fax: 855-237-9113 | Toll Free: 855-237-9112
911B Plum Grove Road | Schaumburg, IL 60173

PATIENT INFORMATION

□ ***Rx for in-office use only***

Patient Name _____ DOB _____ Phone _____

Address _____ City, State _____ Zip _____

Applicable Diagnosis Codes/Descriptions: _____

PLEASE FAX COPY OF FACE SHEET, IF AVAILABLE

PRESCRIPTION INFORMATION

ANTIFUNGAL:
□ Ala-Quin Cream
□ Clotrimazole 1% cream
□ Ciclodan cream
□ Econazole 1% cream
□ Ecoza Foam
□ Kerydin Solution
□ Luzu Cream
□ MetroGel / Cream
□ Miconazole 2% cream
□ Naftin Cream
□ Nystatin Powder
□ Nystatin 100M cream / oint
□ Terbinafine 1% cream
□ Tolnaftate 1% cream
□ Tolnaftate 1% powder
□ Xolegel Gel

Quantity: _____ *Refill:* _____ *Directions:* _____

ECZEMA & RASH:
□ Clobex Spray
□ Cordran Cream / Lotion / Oint
□ Dermasorb AF / HC / TA
□ EpiCeram Emulsion
□ Kenalog Spray
□ Nivatopic Plus Cream
□ Hydro 35 Foam
□ DrySol Solution
□ Topicort (gen) cream /ointment
□ Trianex 0.05% Oint
□ Topicort Spray
□ Vanos Cream

Quantity: _____ *Refill:* _____ *Directions:* _____

KERATOSIS & WARTS:
□ Carac 0.5% Cream
□ Fluoroplex 1% Cream
□ Imiquimod 5% cream
□ Picato 0.015% Gel
□ Salicylic Acid 28.5% Solution
□ Zyclara 2.5% or 3.75% Cream

Quantity: _____ *Refill:* _____ *Directions:* _____

NAIL CARE:
□ Ciclodan Solution
□ Genadur Nail Kit
□ Jublia Solution
□ Nuvail Nail Solution
□ Umecta 40% Nail Solution
□ Uramaxin 45% Nail Gel

Quantity: _____ *Refill:* _____ *Directions:* _____

WOUND CARE, PAIN and INFLAMMATION:
□ Alevicyn Gel
□ Alevicyn Spray
□ Alevicyn SG
□ Dakin's Solution .125 / .25 / .5%
□ Domeboro Packets
□ Intrasite Gel
□ Iodosorb Gel
□ Pennsaid 2% Solution
□ Solaraze 3% Gel
□ Voltaren 2% Gel

Quantity: _____ *Refill:* _____ *Directions:* _____

OTHER ORAL, TOPICAL or COMPOUNDED FORMULA:

□ Drug or Formula: _____

Quantity: _____ *Refills:* _____ *Directions:* _____

□ Drug or Formula: _____

Quantity: _____ *Refills:* _____ *Directions:* _____

PLEASE FAX COPY OF FRONT AND BACK OF ALL INSURANCE CARDS

PRESCRIBING PHYSICIAN

□ ***Rx for in-office use only***

Physician Name _____ Phone _____ Fax _____

_____ NPI/DEA# _____ Date _____

Physician Signature

By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent when handling prior authorizations and other medical and prescription insurance forms and communications