CIENEGA PHARMACY

Solodyn Dermatology Prescription Form

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cienegapharmacy.com

SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________________________

DATE:____________NEEDS BY DATE: ___________

PATIENT INFO

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis (ICD-9 code)

☐ 706.1 - Acne
☐ Other: ____________________

Date of Diagnosis: ________

Additional Patient Information *

Weight:________ Height: ________

Allergies:

Please provide progress notes if available

Comments:

Prior Medications (Tried and Failed)

Medication	Duration (Months)	Reasons for D/C
☐ Antibiotics: ____________		
☐ Benzoyl peroxide alternative(s): ____________		
☐ Cynomycin		
☐ Doxycycline		
☐ Erythromycin		
☐ Minocycline (immediate release)		
☐ Retinoid(s):		
☐ Other: ____________		

Please provide a brief description of the patient's condition:

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG / DIRECTIONS	QTY	REFILLS
☐ **SOLODYN**® minocycline HCL, USP (extended release)	☐ 55 mg ☐ 65 mg ☐ 80 mg ☐ 105 mg ☐ 115 mg ** 45 mg, 90 mg, and 135mg are currently not available*	Take 1 capsule by mouth once daily	30	
☐ **ZIANA**® (clindamycin phosphate 1.2% and tretinoin 0.025%) Gel	1.2-0.025%			
☐ **BENZEFOAM**™ **ULTRA 9.8% FOAM** (benzoyl peroxide)	9.8%			

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

______________________ Prescriber's Signature (no stamps)

__________ Date

__________ If Brand required check ❑ DAW

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