TODT HILL PHARMACY
SPECIALTY PHARMACY

2110 Richmond Road
Staten Island, NY 10306

Toll Free 844.994.0016
Phone 718.351.7363
Fax 718.351.4972
www.todthillspecialtyrx.com
todthillrx@gmail.com

RHEUMATOID ARTHRITIS / OSTEOARTHRITIS

Fax prescription to 718.351.4972
Faxed prescriptions can only be accepted from prescribing practitioners

DATE NEEDED BY .... SHIP to ☐ PATIENT ☐ OFFICE ☐ OTHER ....

PATIENT INFORMATION

NAME ______________________________
ADDRESS ______________________________
CITY ____________________ STATE _____ ZIP ________
PHONE____________________ SS# ______________ DOB ________
☐MALE ☐FEMALE HEIGHT__________ WEIGHT__________ AGE_____
ALLERGIES ______________________________ ☐ NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

NAME ______________________________
NPI ____________________ STATE LICENSE#____________________
GROUP|HOSPITAL ______________________________
ADDRESS______________________________
CITY, STATE, ZIP ______________________________
MAIN PHONE ____________________ FAX____________________
CONTACT PERSON __________________ PHONE __________________

CLINICAL AVALUATION

DIAGNOSIS

☐ B35.1 Tinea Unguium
☐ M17.9 Osteoarthritis
☐ M06.9 Rheumatoid arthritis
☐ B35.1 Tinea Pedis
☐ Other

DIAGNOSIS DATE __________________
YEARS WITH DISEASE________________

PREVIOUS THERAPY FAILED

☐ Topical Antifungal ____________________
☐ Oral Antifungal ____________________
☐ Oral Steroid ____________________
☐ Oral Anti-Inflamatory ____________________

PPRESCRIPTION INFORMATION

MEDICATION	DOSAGE AND DIRECTIONS	QUANTITY | DURATION	REFILLS
☐ DOXEPH CREAM 5% ☐ 45 grams ☐ 90 grams ☐ 180 grams	☐ APPLY 1-2 gr TO THE AFFECTED AREA 3-4 TIMES DAILY AS NEEDED FOR PAIN	☐ ENTER QUANTITY________________	
☐ OXICONAZOLE CREAM 1% ☐ 60 grams ☐ 90 grams	☐ APPLY 1-2 gr TO THE AFFECTED AREA 3-4 TIMES DAILY AS NEEDED FOR FUNGUS	☐ ENTER QUANTITY________________	
☐ OXISTAT LOTION 1% ☐ 30 ml ☐ 60 ml	☐ APPLY TO THE AFFECTED AREA TWICE A DAY	☐ ENTER QUANTITY________________	
☐ KETOCONZOLE FOAM 2% ☐ 100 grams	☐ APPLY 1-2 gr TO THE AFFECTED AREA 3-4 TIMES DAILY AS NEEDED FOR FUNGUS	☐ ENTER QUANTITY________________	
☐ DUEXIS 80 - 26.6 mg ☐ 60 tabs ☐ 90 tabs	☐ ONE TABLET TWICE A DAY ☐ ONE TABLET THREE TIMES A DAY	☐ ENTER QUANTITY________________	
☐ RAYOS ☐ 1 mg ☐ 2 mg ☐ 5 mg	☐ ONE TABLET ONES A DAY ☐ ONE TABLET TWICE A DAY ☐ ONE TABLET THREE TIMES A DAY ☐ PLEASE PROVIDE EXACT DIRECTIONS OR TAPER SCHEDULE	☐ ENTER QUANTITY________________	
☐ NAPROXEN CR ☐ 375 mg ☐ 500 mg	☐ TAKE 2 TABLETS BY MOUTH EVERY DAY AS NEEDED WITH FOOD	☐ ENTER QUANTITY________________	
☐ VIMOVO ☐ 375 mg - 20 ☐60 ☐ 500 mg - 20 ☐60	☐ ONE TABLET TWICE A DAY	☐ ENTER QUANTITY________________ ☐ ENTER QUANTITY________________	
☐ PENNSAID 2% solution ☐112 ml	☐ APPLY TWO PUMPS ACTIVATIONS TO AFFECTED KNEE(S) TWO TIMES A DAY	☐ ENTER QUANTITY________________	
☐ OTHER_______________	☐ DIRECTIONS ____________________________	☐ ENTER QUANTITY________________	

By signing this form and utilizing our services, you are authorizing **TODT HILL PHARMACY INC** and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature ______________________________ ☐ DWA Date__________

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