DEXERYL DIRECT

FOUNDATION CARE

Prescription Order Form Fax:

866-351-4344

Ph: 866-351-4342 ~ 4010 Wedgeway Court ~ Earth City, MO ~ 63045

Patient Information:

Name: _____ ☐ Male ☐ Female Date of Birth: _____

Address_____ City_____ State_____ ZIP_____

Social Security #_____ Allergies_____

Primary Phone _____ Secondary Phone _____ Email_____

Emergency Contact _____ Phone _____ Relationship _____

Please Attach a Copy of Insurance Card(s)

(Front and Back)

Diagnosis / ICD10 Code _____

Product Description	Unit Size	Directions – Please check box to the left	Refills (Circle one or fill in the blank)	Days Supply
Dexeryl Cream	250g	☐ Sig: Apply a thin layer of cream to the areas to be treated two times daily or as needed. ☐ Sig:	3 6 12 _____	30 days or _____

Prescriber Information:

Prescriber Signature: _____/_____ Date _____

(Substitutions Permitted) (Dispense as Written)

Prescriber Name_____ Practice/Facility Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax _____ Email Address: _____

DEA #: _____ NPI #: _____ Physician Specialty _____

Name of Contact Person: _____ Contact Person #, ext or email: _____