nufactor®

Ycanth™ (cantharidin) TOPICAL SOLUTION

For questions, call 1.800.315.0155

YCANTH™ (cantharidin) Topical Solution Orders

Fax all pages to (800) 267-4982

Patient Information

Order Date:	Date of last dose: ☐ naive	Requested Start of Care Date:	Date of birth:
Patient Name:		Height:	Weight: lb / kg
Address:		City:	State: / Zip:
Allergies:			
Primary Diagnosis:		ICD-10:	
Emergency Contact or Legal Guardian (if under 18 years of age):			
Name:	Phone Number:	Relationship to Patient:	

Insurance Information

Please include a copy of insurance card(s).

Insurance Information (Primary)	**Insurance Information (Secondary)**
Insurance Provider:	Insurance Provider:
Policy ID:	Policy ID:
Group:	Group:
Provider Services Phone Number:	Provider Services Phone Number:
Insurance Information (Tertiary)	**Pharmacy Benefit Manager (PBM):**
Insurance Provider:	BIN:
Policy ID:	PCN:
Group:	Group:
Provider Services Phone Number:	

Medication Orders

Please include most recent office visit note for submission to insurance plan.

YCANTH (0.7% w/v cantharidin solution) Single Use Applicator 0.45 ml

Instructions:	To be applied topically to lesions by a medical professional. May repeat in three weeks as necessary.			
Choose 1 dispensing option	☐ Option 1	Dispense Quantity: 2	Refills: _____	Unless noted, prescriptions valid 1 year from date signed.
	☐ Option 2	Dispense Quantity: 1	Refills: _____	

Additional Information

Physician Information

Signature:	MD Name:
	NPI#:
	Office Coordinator Name:
	Phone #: / Email Address:
	Office Address:
Date:	Shipping Address (☐ same as above):
	Phone: / Fax:

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