

Patient Enrollment Form

For the On-Label Use of YCANTH



[*required fields]

Patient Information

*Patient Name: _____

Male Female *DOB: / / Preferred Language: English Spanish Other

*Address: _____

City/State/Zip: _____

*Home Phone: _____ *Cell Phone: _____

Email: _____

*Parent/Guardian Name: _____ Relationship to Patient: _____

*Contact Phone: _____

Insurance Information

Patient has no insurance coverage. Please include a copy of front and back of patient's insurance card(s).

*Primary: _____ *Policy ID#: _____ *Group#: _____

Subscriber's Name (if not self): _____ DOB: / /

Relationship to Patient: _____ Employer: _____

Secondary: _____ Policy ID# _____ Group#: _____

Subscriber's Name (if not self): _____ DOB: / /

Relationship to Patient: _____ Employer: _____

Pharmacy Benefit: Yes No Carrier: _____

Policy/Group#: _____ Member ID: _____

Physician Information

*Prescriber Name: _____ Specialty: _____

Practice Name: _____ Office Contact: _____

*NPI#: _____ *State Med Lic#: _____ Tax ID#: _____

*Address: _____

*City/State/Zip: _____

*Phone: _____ *Fax: _____

Email: _____

Clinical Information

Sample Product Administered? Yes No

*ICD-10 Code: _____

*CPT Code Description: *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions*

CPT 17110 (Up to 14 lesions) CPT 17111 (15 or more lesions)

Prescription Information

Rx: YCANTH (cantharidin) topical solution 0.7% for the FDA-approved treatment of molluscum contagiosum

Quantity: _____ Refill: _____ times Days' Supply: _____

Directions: _____

Dispense as Written Substitutions Allowed

By signing below, I certify that (a) the above-prescribed therapy for molluscum contagiosum is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to manufacturer and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

*Prescriber's Signature **NO STAMPS PLEASE:** _____

Date: _____



Monday-Friday (8 AM-8 PM ET)

Toll-free Phone:
1-855-YCANTHS (1-855-922-6847)

Toll-free Fax:
1-844-YCANTHS (1-844-922-6847)



For illustrative purposes only

Please see Important Safety Information and full Prescribing Information at YCANTHPro.com

YCANTH and Y-Access are registered trademarks of Verrica Pharmaceuticals Inc. Copyright © 2024, Verrica Pharmaceuticals Inc. All rights reserved. (04/24) US-YCN-00003P

