Dermatology

Patient Information

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Social Security Number:	E-Mail:		
Allergies (Required): ☐ NKDA		Height:	Weight:
Product Shipping Options ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:			

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Notes: Please send last 3 available chart notes and lab results with order

Clinical Information

Diagnosis/ICD-10:	Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐ Yes ☐ No	Does the patient have a latex allergy? ☐ Yes ☐ No
TB/PPD test given? ☐ Yes ☐ No ****Please send documentation****	Prior Failed Medications: ☐ Methotrexate ☐ PUVA ☐ Other: ☐ Topical:	% BSA affected: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Cosentyx®	☐ 150 mg/mL Sensoready® pen ☐ 150 mg/mL prefilled syringe	☐ Starter: Inject 150 mg Sub-Q on week 0, 1, 2, 3 and 4 ☐ Starter: Inject 300 mg Sub-Q on week 0, 1, 2, 3 and 4 (**plaque psoriasis**) ☐ Maintenance: Inject 150 mg Sub-Q once every 4 weeks ☐ Maintenance: Inject 300 mg Sub-Q once every 4 weeks	5 week supply 1 month supply	0
☐ Dupixent®	300 mg/2 mL prefilled syringe	Inject 600 mg Sub-Q day 1, then inject 300 mg Sub-Q every other week starting day 15	2 PFS	
☐ Enbrel®	☐ 50 mg/mL SureClick™ autoinjector ☐ 50 mg/mL prefilled syringe ☐ 50 mg mini cartridge	☐ Starter: Inject 50 mg Sub-Q twice a week (72-96 hours apart for 3 months)	1 month supply	2
		☐ Maintenance: Inject 50 mg Sub-Q once a week	4 pens/PFS/ cartridges	
☐ Humira®	☐ 40 mg/0.8 mL pen starter kit ☐ 40 mg/0.8 mL prefilled syringe	☐ Starter: Inject 80 mg Sub-Q day 1, 40 mg Sub-Q day 8, and 40 mg Sub-Q day 22 ☐ Starter: Inject 160 mg Sub-Q day 1 and 80 mg Sub-Q day 15 (**hidradenitis suppurativa**)	1 month supply	0
	☐ 40 mg/0.8 mL pen ☐ 40 mg/0.8 mL prefilled syringe	☐ Maintenance: Inject 40 mg Sub-Q every other week ☐ Maintenance: Inject 40 mg Sub-Q every week (**hidradenitis suppurativa**)	2 pens/PFS	
☐ Humira® citrate-free	☐ 80 mg/0.8 mL pen starter kit ☐ 40 mg/0.4 mL prefilled syringe	☐ Starter: Inject 80 mg Sub-Q day 1, 40 mg Sub-Q day 8, and 40 mg Sub-Q day 22 ☐ Starter: Inject 160 mg Sub-Q day 1 and 80 mg Sub-Q day 15 (**hidradenitis suppurativa**)	1 month supply	0
	☐ 40 mg/0.4 mL pen ☐ 40 mg/0.4 mL prefilled syringe	☐ Maintenance: Inject 40 mg Sub-Q every other week ☐ Maintenance: Inject 40 mg Sub-Q every week (**hidradenitis suppurativa**)	2 pens/PFS	
☐ Ilumya™	100 mg/ml prefilled syringe	☐ Starter: Inject 100 mg Sub-Q at weeks 0, 4 and then every 12 weeks after ☐ Maintenance: Inject 100mg Sub-Q every 12 weeks	1 PFS	
☐ Otezla®	☐ Starter Pack	Titrate dose days 1 through 5 and as directed thereafter	1 Pack	0
	☐ Bridge Pack ☐ 30 mg tablet	☐ take one tablet by mouth twice daily – OR – ☐ take one tablet by mouth daily Take 30 mg by mouth twice daily **(Titration date: ____/____/____)**	28 tablets 60 tablets	
☐ Siliq™	210 mg/1.5 mL prefilled syringe	☐ Starter: inject 210 mg Sub-Q at weeks 0 and 1 ☐ Maintenance: inject 210mg Sub-Q at week 2 and every 2 weeks thereafter	2 PFS	0
☐ Simponi®	☐ 50 mg/0.5 mL SmartJect® autoinjector ☐ 50 mg/0.5 mL prefilled syringe	Inject 50 mg Sub-Q once a month (**psoriatic arthritis**)	1 pen/PFS	
☐ Stelara®	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/1 mL prefilled syringe	☐ Starter: Inject the contents of 1 syringe Sub-Q on week 0, week 4, then every 12 weeks ☐ Maintenance: Inject the contents of 1 syringe Sub-Q every 12 weeks	1 PFS	
☐ Taltz®	☐ 80 mg/ml autoinjector ☐ 80 mg/ml prefilled syringe	☐ Starter: inject 160 mg Sub-Q at week 0 and 80 mg Sub-Q at week 2	3 pens/PFS	0
		☐ Induction: inject 80 mg Sub-Q every 2 weeks (weeks 4-10)	2 pens/PFS	1
		☐ Maintenance: inject 80 mg Sub-Q at week 12 and then every 4 weeks thereafter	1 pen/PFS	
☐ Tremfya™	100 mg/ml prefilled syringe	☐ Starter: inject 100 mg Sub-Q at weeks 0, 4 and then every 8 weeks after ☐ Maintenance: inject 100mg Sub-Q every 8 weeks	1 PFS	
☐ Other:				

Prescriber Signature and Date (Please sign and date below)

_____ _____

Substitution Permissible Date Dispense as Written Date

☐ Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"