

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			City:	State:	Zip:
Phone Number:		Alternate Phone Number:		Language:	
Allergies (Required):		<input type="checkbox"/> NKDA	Height:	Weight:	SSN:
Product Shipping Options: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:					

Prescriber Information

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

Clinical Information – Please send all available chart notes including lab results

Diagnosis/ICD-10: _____	Prior Failed Medications: <input type="checkbox"/> Enbrel® <input type="checkbox"/> Humira® <input type="checkbox"/> Methotrexate <input type="checkbox"/> PUVA <input type="checkbox"/> Simponi® <input type="checkbox"/> Stelara® <input type="checkbox"/> Other: _____ <input type="checkbox"/> Topical (please list): _____		Does the patient have a latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No
TB/PPD test given? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Hepatitis B ruled out? <input type="checkbox"/> Yes <input type="checkbox"/> No	% BSA affected:	IGA Score: _____
Please provide documentation		<input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia	
If no, has treatment started? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Prescription Information

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia® (psoriatic arthritis)	<input type="checkbox"/> 200 mg prefilled syringe	<input type="checkbox"/> Starter dose: inject 400 mg Sub-Q at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance dose: inject 400 mg Sub-Q every 4 weeks <input type="checkbox"/> Maintenance dose: inject 200 mg Sub-Q every 2 weeks	1 Starter pack 2 syringes	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150 mg/mL Sensoready® pen <input type="checkbox"/> 150 mg/mL prefilled syringe	With a loading dose: <input type="checkbox"/> Inject 150 mg Sub-Q on week 0, 1, 2, 3 and 4 then inject 150 mg Sub-Q once every 4 weeks (FOR PSORIATIC ARTHRITIS) Without a loading dose: <input type="checkbox"/> Inject 150 mg Sub-Q once every 4 weeks (FOR PSORIATIC ARTHRITIS) <input type="checkbox"/> Inject 300 mg Sub-Q on week 0, 1, 2, 3 and 4 then inject 300 mg Sub-Q once every 4 weeks <input type="checkbox"/> Inject 300 mg Sub-Q every 4 weeks (FOR PLAQUE PSORIASIS)	1 pen/syringe 3 pens/syringes	
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300 mg/2 mL solution in a single-dose pre-filled syringe with needle shield	<input type="checkbox"/> Starter dose: inject 600 mg (2 syringes in 2 different injection sites) Sub-Q day 1 <input type="checkbox"/> Maintenance dose: inject 300 mg Sub-Q every other week (starting 14 days after day 1)	2 syringes	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50 mg/mL prefilled syringe <input type="checkbox"/> 50 mg/mL SureClick™ autoinjector	<input type="checkbox"/> Starter dose: inject 50 mg Sub-Q twice a week (72-96 hours apart for 3 months) <input type="checkbox"/> Maintenance dose: inject 50 mg Sub-Q once a week	8 pens/syringes 4 pens/syringes	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg/0.8 mL pen <input type="checkbox"/> 40 mg/0.8 mL prefilled syringe	<input type="checkbox"/> Starter dose: inject 80 mg Sub-Q day 1 <input type="checkbox"/> Maintenance dose: inject 40 mg Sub-Q every other week (starting 1 week after initial dose) For Hidradenitis Suppurativa only: <input type="checkbox"/> Starter dose: inject 160 mg Sub-Q day 1, then 80 mg 14 days after, then 40 mg on day 29 <input type="checkbox"/> Maintenance dose: inject 40 mg Sub-Q every week (starting 1 week after day 29 dose)	<input type="checkbox"/> Starter pack <input type="checkbox"/> 2 pens/syringes <input type="checkbox"/> Starter pack <input type="checkbox"/> 4 pens/syringes	
<input type="checkbox"/> Ilumya™	<input type="checkbox"/> 100 mg/mL prefilled syringe	<input type="checkbox"/> Starter Dose: inject 100 mg Sub-Q at week 0 and week 4 <input type="checkbox"/> Maintenance dose: inject 100 mg Sub-Q every 12 weeks	1 prefilled syringe	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Pack <input type="checkbox"/> Bridge Pack <input type="checkbox"/> 30 mg tablet	Titrate dose days 1 through 5 and as directed thereafter <input type="checkbox"/> Take 30 mg by mouth once daily <input type="checkbox"/> Take 30 mg by mouth twice daily Take 30 mg by mouth twice daily (Titration Date: ___/___/___)	1 pack 28 tabs 60 tabs	
<input type="checkbox"/> Simponi® (psoriatic arthritis)	<input type="checkbox"/> 50 mg/0.5 mL SmartJect® autoinjector <input type="checkbox"/> 50 mg/0.5 mL prefilled syringe	Inject 50 mg Sub-Q once a month	1 pen/syringe	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45 mg/0.5 mL prefilled syringe (<100 kg) <input type="checkbox"/> 90 mg/1 mL prefilled syringe (>100 kg)	<input type="checkbox"/> Inject contents of 1 syringe Sub-Q on day 0, 4 weeks later, and then every 12 weeks <input type="checkbox"/> Inject 1 syringe Sub-Q every 12 weeks	1 syringe	
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80 mg/ml autoinjector <input type="checkbox"/> 80 mg/ml prefilled syringe	<input type="checkbox"/> Starter dose: inject 160 mg Sub-Q at week 0, then begin induction dose 2 weeks later <input type="checkbox"/> Induction dose: inject 80 mg Sub-Q every two weeks (weeks 4 – 10) <input type="checkbox"/> Final Induction dose: inject 80 mg Sub-Q at week 12 <input type="checkbox"/> Maintenance dose: inject 80 mg Sub-Q every 4 weeks (thereafter)	3 pens/syringes 2 pens/syringes 1 pen/syringe 1 pen/syringe	
<input type="checkbox"/> Tremfya™	100 mg/ml prefilled syringe	<input type="checkbox"/> Starter dose: inject 100 mg Sub-Q at weeks 0, 4 and then every 8 weeks after <input type="checkbox"/> Maintenance dose: inject 100mg Sub-Q every 8 weeks	1 syringe	
<input type="checkbox"/> Siliq™	210 mg/1.5 mL prefilled syringe	<input type="checkbox"/> Starter dose: inject 210 mg Sub-Q at weeks 0, 1 and 2 and then then every 2 weeks after <input type="checkbox"/> Maintenance dose: inject 210mg Sub-Q every 2 weeks	2 pens	
<input type="checkbox"/> Xeljanz®	5 mg tablets	Take 1 tablet by mouth twice daily for psoriatic arthritis	60 tabs	
<input type="checkbox"/> Xeljanz® XR	11 mg tablets	Take 1 tablet by mouth daily with or without food for psoriatic arthritis	30 tabs	
<input type="checkbox"/> Other:				

Prescriber Signature and Date (Please sign and date below)

Dispense as Written	Date	Substitution Permissible	Date
<input type="checkbox"/> Check here to authorize Curexa™ 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"			