curexa Pharmacy

# Dermatology

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

| | | | |
|---|---|---|---|
| Patient Name: | | Date of Birth: | ☐ Male ☐ Female |
| Address: | City: | State: | Zip: |
| Phone Number: | Alternate Phone Number: | Language: | |
| **Allergies (Required):** ☐ NKDA | Height: | Weight: | SSN: |

**Product Shipping Options**: ☐ Patient's Home ☐ Prescriber Office ☐ 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: ☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ PUVA<br>☐ Simponi® ☐ Stelara® ☐ Other:____________ ☐ Topical (please list): ________ | Does the patient have a latex allergy?<br>☐ Yes ☐ No |
| TB/PPD test given? ☐ Yes ☐ No<br>Date of negative test: | Is Hepatitis B ruled out? ☐ Yes ☐ No<br>If no, has treatment started? ☐ Yes ☐ No | % BSA affected:<br>☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia |

## Prescription Information

| Medication | Dose | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ Cimzia® (psoriatic arthritis) | ☐ 200 mg prefilled syringe | ☐ Starter dose: inject 400 mg Sub-Q at weeks 0, 2, and 4 | ☐ 1 kit ☐ 3 kits | |
| | | ☐ Maintenance dose: inject 400 mg Sub-Q every 4 weeks<br>☐ Maintenance dose: inject 200 mg Sub-Q every 2 weeks | 1 kit | |
| ☐ Cosentyx® | ☐ 150 mg/mL Sensoready® pen<br>☐ 150 mg/mL prefilled syringe | With a loading dose:<br>☐ 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)<br>Without a loading dose:<br>☐ Inject 150 mg Sub-Q once every 4 weeks (FOR PSORIATIC ARTHRITIS)<br>☐ Inject 300 mg Sub-Q on week 0, 1, 2, 3 and 4 then inject 300 mg Sub-Q once every 4 weeks (FOR PLAQUE PSORIASIS) | 3 | |
| ☐ Dupixent® | ☐ 300 mg/2 mL solution in a single-dose pre-filled syringe with needle shield | ☐ Starter dose: inject 600 mg (2 syringes in 2 different injection sites) Sub-Q day 1<br>☐ Maintenance dose: inject 300 mg Sub-Q every other week (starting 14 days after day 1) | ☐ 2 syringes<br>☐ 4 syringes | |
| ☐ Enbrel® | ☐ 50 mg/mL prefilled syringe<br>☐ 50 mg/mL SureClick™ autoinjector | ☐ Starter dose: inject 50 mg Sub-Q twice a week (72-96 hours apart for 3 months) | 8 | |
| | | ☐ Maintenance dose: inject 50 mg Sub-Q once a week | 4 | |
| ☐ Humira® | ☐ 40 mg/0.8 mL pen<br>☐ 40 mg/0.8 mL prefilled syringe | ☐ Starter dose: inject 80 mg Sub-Q day 1<br>☐ Maintenance dose: inject 40 mg Sub-Q every other week (starting 1 week after initial dose)<br>For Hidradenitis Suppurativa only:<br>☐ Starter dose: inject 160 mg Sub-Q day 1, then 80 mg 14 days after, then 40 mg on day 29<br>☐ Maintenance dose: inject 40 mg Sub-Q every week (starting 1 week after day 29 dose) | ☐ 2 ☐ 4<br>☐ Starter pack | |
| ☐ Otezla® | ☐ Starter Pack | Titrate dose days 1 through 5 and as directed thereafter | 1 pack | |
| | ☐ 30 mg tablet | Take 30 mg by mouth twice daily | 60 | |
| ☐ Simponi® (psoriatic arthritis) | ☐ 50 mg/0.5 mL SmartJect® autoinjector<br>☐ 50 mg/0.5 mL prefilled syringe | Inject 50 mg Sub-Q once a month | 1 | |
| ☐ Stelara® | ☐ 45 mg/0.5 mL prefilled syringe<br>☐ 90 mg/1 mL prefilled syringe | Inject contents of 1 syringe Sub-Q on day 0, 4 weeks later, and then every 12 weeks | 1 syringe | |
| ☐ Taltz® | ☐ 80 mg/ml autoinjector<br>☐ 80 mg/ml prefilled syringe | ☐ Starter dose: inject 160 mg Sub-Q at week 0 | 3 pack | |
| | | ☐ Maintenance dose: inject 80 mg Sub-Q every 2 weeks until week 12, then every 4 weeks after<br>☐ Maintenance dose: inject 80 mg Sub-Q every 4 weeks | ☐ 1 pack<br>☐ 2 pack | |
| ☐ Tremfya™ | 100 mg/ml prefilled syringe | ☐ Starter dose: inject 100 mg Sub-Q at weeks 0, 4 and then every 8 weeks after | 1 syringe | |
| | | ☐ Maintenance dose: inject 100mg Sub-Q every 8 weeks | | |
| ☐ Other: | | | | |

## Prescriber Signature and Date (Please sign and date below)

______________________________________ ______________________________________
Dispense as Written Date Substitution Permissible Date

☐ 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"

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