Dermatology I-Z

Select Location

Avita
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DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER _____

PATIENT INFORMATION

Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	❑ Male ❑ Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type	❑ Physician (MD or DO) ❑ Nurse Practitioner	❑ Physician's Assistant
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

	PRESCRIPTION INFORMATION		QUANTITY	REFILLS
❑ Ilumya™	100 mg Pre-filled syringe	❑ **INITIAL:** Inject 100 mg SQ at week 0 and week 4 ❑ **MAINTENANCE:** Inject 100 mg SQ every 12 weeks thereafter	1 1	1 _____
❑ Otezla®	❑ Starter Pack ❑ 30mg Tablets	❑ **Titrate:** Take 1 tablet on day 1 then twice daily as directed **OR date provided** _____ ❑ **Maintenance:** Take 1 tablet by mouth **ONCE** daily ❑ **Maintenance:** Take 1 tablet by mouth **TWICE** daily.	1 Starter Pack 30 60	_____
❑ Otezla® *Bridge Rx*	30mg Tablets	❑ Bridge Rx: Take 1 tablet by mouth **TWICE** daily; dispensed by OSP **(Recommended daily dose) ***Starter Pack Provided Date:** _____ ❑ Bridge Rx: Take 1 tablet by mouth **ONCE** daily; dispensed by OSP **(For Patients with severe renal impairment)**	28	6 12
❑ Siliq™	210mg Pre-filled Syringe	❑ **Initial:** Inject 210 mg SQ on weeks 0, 1, and 2 ❑ **Maintenance:** Inject 210 mg SQ every 2 weeks starting at week 4	3 4 Week Supply	0 _____
❑ Skyrizi™	75 mg Pre-filled Syringe	❑ **Initial:** Inject 150 mg (2 syringes) SQ at weeks 0 & 4 ❑ **Maintenance:** Inject 150 mg (2 syringes) SQ every 12 weeks	1 box (2 syringes) 1 box (2 syringes)	1 _____
❑ Stelara®	❑ 45mg Pre-filled Syringe ❑ 90mg Pre-filled Syringe **Weight Required:** _____	❑ Inject 45mg on day 0, then week 4, then every 12 weeks **(Patients ≤ 220lbs)** ❑ Inject 90mg on day 0, then week 4, then every 12 weeks **(Patients > 220lbs)**	4 Week Supply	_____
❑ Tremfya™	❑ One- Press Injector ❑ Pre-filled Syringe	❑ **Initial:** Inject 100 mg SQ at week 0 and then at week 4 ❑ **Maintenance:** Inject 100 mg SQ every 8 weeks	1 1	1 _____
❑ Taltz®	❑ Auto Injector ❑ Prefilled Syringe	❑ **Starting:** Inject 160 mg SQ on day 1, then begin first induction dose 2 weeks later (week 2) ❑ **Induction:** Inject 80 mg SQ every 2 weeks (weeks 4-10) ❑ **Final Induction Dose:** Inject 80 mg SQ on week 12 ❑ **Maintenance:** Inject 80 mg SQ every 4 weeks (thereafter)	3 2 1 1	0 1 0 _____
❑ Taltz® Psoriatic Arthritis Only	❑ Auto Injector ❑ Pre-filled Syringe	❑ **Initial:** Inject 160 mg SQ on week 0 ❑ **Maintenance:** Inject 80 mg SQ every 4 weeks	2 1	_____

CLINICAL INFORMATION

Diagnosis: ❑ L40.0 Moderate to Severe Plaque Psoriasis ❑ L40.50 Psoriatic Arthritis ❑ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
❑ Other: _____ DX Code: _____ ❑ L20.9 Atopic Dermatitis unspecified

Location: % BSA:_____ ❑ Hands ❑ Feet ❑ Scalp ❑ Groin ❑ Nails ❑ Other: _____ | Patient Allergies:

Prior Failed Meds: ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Orencia ❑ Remicade ❑ Simponi ❑ Soriatane ❑ Stelara ❑ Taltz

Methotrexate Length of Treatment:_____ Reason for Discontinuing:_____
PUVA/UVB Length of Treatment:_____ Reason for Discontinuing:_____
Topicals Length of Treatment:_____ Reason for Discontinuing:_____
Contraindicated Medication:_____ Reason:_____
Inadequate Response (*List Specific Names*):_____

Weight:	Height:	Hepatitis Test Result:	Hep B ruled out/treated: ❑ Yes ❑ No Date:
TB/PPD Test given? ❑ Yes ❑ No Test Date:		Test Results:	ISGA score: EASI score: POEM score: SCORAD:
Additional Information:			

Dispense As Written (no stamps) _____ **Date** _____ **Substitution Permitted** (no stamps) _____ **Date** _____

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.