

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE - FIRST DOSE  OFFICE - ALL DOSES  OTHER \_\_\_\_\_

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name			Prescriber Name		
Address			Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant		
City			Supervising Physician (If prescriber is a NP or PA)		
State	Zip		DEA # NPI # Tax ID #		
Main Phone			Address		
Alternative Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female		City State Zip		
Social Security #		Date of Birth	Phone Fax		
			Contact Person		

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

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> <b>INITIAL:</b> Inject 400 mg SQ at weeks 0, 2, and 4 <input type="checkbox"/> <b>PSORIATIC MAINTENANCE:</b> Inject 200 mg SQ every 2 weeks <b>OR</b> <input type="checkbox"/> Inject 400 mg SQ every 4 weeks <input type="checkbox"/> <b>PSORIASIS MAINTENANCE:</b> Inject 400 mg SQ every 2 weeks <b>OR</b> <input type="checkbox"/> Inject 200 mg SQ every 2 weeks (≤ 90kg)	1 Starter Kit 4 Week Supply	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> SensorReady Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) <input type="checkbox"/> <b>INITIAL:</b> Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10)	<input type="checkbox"/> <b>MAINTENANCE:</b> Inject 150 mg SQ every 4 weeks (Qty 1) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks (Qty 2)	
<input type="checkbox"/> Cosentyx® <i>Covered Until You're Covered</i>	<input type="checkbox"/> SensorReady Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) <input type="checkbox"/> <b>INITIAL:</b> Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10)	<input type="checkbox"/> <b>MAINTENANCE:</b> Inject 150 mg SQ every 4 weeks (Qty 1) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks (Qty 2)	
<input type="checkbox"/> Dupixent®	<b>Adult patients aged ≥18 years</b> 300mg/2mL Syringe - 2 Pack	<input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ at day 1. Starting on day 15, inject 300 mg every other week <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg every other week	Loading Dose 4 Week Supply	
<input type="checkbox"/> Dupixent®	<b>Pediatric patients aged 6-17 years:</b> Weight: _____ kg (1 kg=2.2 lb) Pre-filled syringe - 2 Pack	<b>Weight 15 to &lt;30 kg:</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ at day 1. <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks, starting on day 29	Loading Dose 8 Week Supply	
		<b>Weight 30 to &lt;60 kg:</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 400 mg SQ at day 1. <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 200 mg SQ every 2 weeks, starting at day 15	Loading Dose 4 Week Supply	
		<b>Weight ≥60 kg:</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ at day 1. Starting on day 15, inject 300 mg every other week <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg every other week	Loading Dose 4 Week Supply	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Sureclick Pen <input type="checkbox"/> Vials 25mg <input type="checkbox"/> Mini with AutoTouch Pre-filled Syringe <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> <b>INITIAL:</b> Inject 50 mg SQ TWICE a week 72-96 hours apart <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 50 mg SQ ONCE a week <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 25 mg SQ TWICE a week 72-96 hours apart	4 Week Supply	2
<input type="checkbox"/> Humira® <i>Citrate Free</i>	<input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 80mg SQ on day 1, 40mg on day 8, then 40mg every <b>other</b> week <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 40 mg SQ <b>every other</b> week	3 2	
	<input type="checkbox"/> HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting on day 29 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 40mg SQ <b>every week</b>	3 4	
	<input type="checkbox"/> Adolescent HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <b>weight required:</b> _____	<input type="checkbox"/> <b>INITIAL:</b> Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting on day 29 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 40 mg SQ <b>every week</b> *** Intended for weight ≥ 60 kg	3 4	0
		<input type="checkbox"/> <b>INITIAL:</b> Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg <b>every other</b> week <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 40 mg SQ <b>every other</b> week ***Intended for weight 30 kg to <60kg	3 2	0

**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.