# Dermatology A-H

Select Location

avitapharmacy.com

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

## 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:

LEFT BLANK

## PATIENT INFORMATION

| Patient Name | Date of Birth | Prescription Date |
|---|---|---|
| | | |

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

**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.