

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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION		
Prescriber Name		
Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> 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: <input type="checkbox"/> L40.0 Moderate to Severe Plaque Psoriasis <input type="checkbox"/> L40.50 Psoriatic Arthritis <input type="checkbox"/> L73.2 Hidradenitis Suppurativa - Hurley Stage: _____ <input type="checkbox"/> Other: _____ DX Code: _____ <input type="checkbox"/> L20.9 Atopic Dermatitis unspecified	
Location: % BSA: _____ <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Scalp <input type="checkbox"/> Groin <input type="checkbox"/> Nails <input type="checkbox"/> Other: _____	Patient Allergies:
Prior Failed Meds: <input type="checkbox"/> Cimzia <input type="checkbox"/> Cosentyx <input type="checkbox"/> Enbrel <input type="checkbox"/> Humira <input type="checkbox"/> Orencia <input type="checkbox"/> Remicade <input type="checkbox"/> Simponi <input type="checkbox"/> Soriatane <input type="checkbox"/> Stelara <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
TB/PPD Test given? <input type="checkbox"/> Yes <input type="checkbox"/> No Test Date: _____	Test Results: _____
ISGA score: _____	EASI score: _____
POEM score: _____	SCORAD: _____
Additional Information:	

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PATIENT INFORMATION

Patient Name	Date of Birth	Prescription Date
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PRESCRIPTION INFORMATION

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

Dispense As Written (no stamps)	Date	Substitution Permitted (no stamps)	Date
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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.