

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			QUANTITY	REFILLS
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg SQ at weeks 0, 2, and 4 <input type="checkbox"/> PSORIATIC MAINTENANCE: Inject 200 mg SQ every 2 weeks OR <input type="checkbox"/> Inject 400 mg SQ every 4 weeks <input type="checkbox"/> PSORIASIS MAINTENANCE: Inject 400 mg SQ every 2 weeks OR <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"/> INITIAL: Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Qty 1) <input type="checkbox"/> INITIAL: Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10) <input type="checkbox"/> MAINTENANCE: 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"/> INITIAL: Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Qty 1) <input type="checkbox"/> INITIAL: Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Qty 2)		
<input type="checkbox"/> Dupixent®	Adult patients aged ≥18 years 300mg/2mL Syringe - 2 Pack	<input type="checkbox"/> INITIAL: Inject 600 mg SQ at day 1. Starting on day 15, inject 300 mg every other week <input type="checkbox"/> MAINTENANCE: Inject 300 mg every other week	Loading Dose 4 Week Supply	
<input type="checkbox"/> Dupixent®	Pediatric patients aged 6-17 years: Weight: _____ kg (1 kg=2.2 lb) Pre-filled syringe - 2 Pack	Weight 15 to <30 kg: <input type="checkbox"/> INITIAL: Inject 600 mg SQ at day 1. <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks, starting on day 29	Loading Dose 8 Week Supply	
		Weight 30 to <60 kg: <input type="checkbox"/> INITIAL: Inject 400 mg SQ at day 1. <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every 2 weeks, starting at day 15	Loading Dose 4 Week Supply	
		Weight ≥60 kg: <input type="checkbox"/> INITIAL: Inject 600 mg SQ at day 1. Starting on day 15, inject 300 mg every other week <input type="checkbox"/> MAINTENANCE: 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"/> INITIAL: Inject 50 mg SQ TWICE a week 72-96 hours apart <input type="checkbox"/> MAINTENANCE: Inject 50 mg SQ ONCE a week <input type="checkbox"/> MAINTENANCE: Inject 25 mg SQ TWICE a week 72-96 hours apart	4 Week Supply	<u>2</u>
<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"/> INITIAL: Inject 80mg SQ on day 1, 40mg on day 8, then 40mg every other week <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week	3 2	
	<input type="checkbox"/> HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> INITIAL: 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"/> MAINTENANCE: Inject 40mg SQ every week	3 4	
	<input type="checkbox"/> Adolescent HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe weight required: _____	<input type="checkbox"/> INITIAL: 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"/> MAINTENANCE: Inject 40 mg SQ every week *** Intended for weight ≥ 60 kg	3 4	<u>0</u>
		<input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week ***Intended for weight 30 kg to <60kg	3 2	<u>0</u>
<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.