



Dermatology

Delivery Need By: _____ Deliver to: Patient's Home Physician's Office Other _____

PATIENT INFORMATION

Patient Name: _____ Male
Address: _____ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Last PPD Test: Positive Negative Date: _____
Allergies: _____

Has the patient been treated previously for this condition?
 Yes No
Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	<input type="checkbox"/> 162 mg/0.9 ml single-dose prefilled syringe <input type="checkbox"/> 162 mg/0.9 ml autoinjector	<input type="checkbox"/> Inject 162 mg SC every OTHER week <input type="checkbox"/> Inject 162 mg SC every week <input type="checkbox"/> Other	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Botox®	<input type="checkbox"/> 100U Vial <input type="checkbox"/> 200U Vial	<input type="checkbox"/> Inject _____ units every _____ weeks	<input type="checkbox"/> _____ vials	
Cimzia®	<input type="checkbox"/> 200 mg/ml Prefilled SYR <input type="checkbox"/> Starter Kit	<u>Loading Dose:</u> <input type="checkbox"/> Inject 400 mg SC at weeks 0, 2 and 4 <input type="checkbox"/> Other	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 200 mg SC every other week <input type="checkbox"/> Inject 400 mg SC every 4 weeks	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other
Cosentyx <i>*Enhanced Specialty Pharmacy Program Participant</i>	<input type="checkbox"/> 150 mg Pen <input type="checkbox"/> 150 mg SYR	<u>Loading Dose:</u> <input type="checkbox"/> Inject 150 mg SC at weeks 0, 1, 2, 3, 4 <input type="checkbox"/> Inject 400 mg SC at weeks 0, 1, 2, 3, 4	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 150 mg SC every 4 weeks <input type="checkbox"/> Inject 300 mg SC every 4 weeks	<input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> 4 week supply (loading) <input type="checkbox"/> Other
Cosentyx <i>*Enhanced Specialty Pharmacy Program Participant</i> Covered Until You're Covered	<input type="checkbox"/> 150 mg Pen <input type="checkbox"/> 150 mg SYR	<u>Loading Dose:</u> <input type="checkbox"/> Inject 150 mg SC at weeks 0, 1, 2, 3, 4 <input type="checkbox"/> Inject 400 mg SC at weeks 0, 1, 2, 3, 4	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 150 mg SC every 4 weeks <input type="checkbox"/> Inject 300 mg SC every 4 weeks	<input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> 4 week supply (loading) <input type="checkbox"/> Other
Dupixent®	<input type="checkbox"/> 300 mg/ml Prefilled SYR	<u>Loading Dose:</u> <input type="checkbox"/> Inject two 300 mg SC once	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 300 mg SC every 4 weeks	<input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> 4 week supply (maintenance)
Enbrel® Enbrel Mini Available	<u>Standard:</u> <input type="checkbox"/> 25mg/0.5ml Prefilled SYR <input type="checkbox"/> 50mg/ml Single Use Prefilled SYR <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 25mg Vial <u>Mini:</u> <input type="checkbox"/> 50mg Enbrel Mini single dose prefilled cartridge	<input type="checkbox"/> Inject 50mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> Inject 25mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Other	<input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> Other	
Humira HS Starter Kit	<input type="checkbox"/> 40 mg/0.8 ml Pen x 6 (Starter Kit) <input type="checkbox"/> 80 mg.0.8ml Pen x3 (Citrate-Free)	<u>Loading Dose:</u> <input type="checkbox"/> Inject 160 mg SC day 1, 80 mg day 15, maintenance beginning on day 29 <input type="checkbox"/> Inject 80 mg SC Day 1, 80mg Day 2, 80mg on Day 15, maintenance beginning on day 29	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: _____ Date: _____



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PRESCRIPTION INFORMATION					
Medication:	Dosage/Strength:	Directions:		Quantity:	Refills:
Humira® Psoriasis/Uveitis Starter Kit Citrate-Free	<input type="checkbox"/> 40mg/0.8ml Pen x4 (Starter Kit) <input type="checkbox"/> 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2	Loading Dose: <input type="checkbox"/> Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22		<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Humira®	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled SYR <input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled SYR (Citrate-Free)	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week		<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Inflectra®	<input type="checkbox"/> 100 mg VIAL	Loading Dose: <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter	Maintenance Dose: <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV every 8 weeks	<input type="checkbox"/> _____ Vials	
Otezla®	<input type="checkbox"/> 28 day starter pack titration <input type="checkbox"/> 30mg	<input type="checkbox"/> Initial dosage titration per starter pack <input type="checkbox"/> 30mg twice daily taken orally		<input type="checkbox"/> 1 month starter pack <input type="checkbox"/> Bottle of 60 <input type="checkbox"/> Other	
Remicade®	<input type="checkbox"/> 100 MG VIAL	Loading Dose: <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV at 0, 2, and 6 weeks then every 8 weeks thereafter	Maintenance Dose: <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV every 8 weeks <input type="checkbox"/> IV _____ mg every _____ weeks	<input type="checkbox"/> _____ Vials	
Renflexis™	<input type="checkbox"/> 100 MG VIAL	Induction Dose: <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter.	<input type="checkbox"/> Maintenance Dose: 5mg/kg (Dose _____ mg) IV every 8 weeks	<input type="checkbox"/> _____ Vials	
Siliq™	<input type="checkbox"/> 210mg/1.5ml Prefilled SYR	<input type="checkbox"/> Inject 210mg SC at weeks: 0, 1 and 2 and 210mg SC every 2 weeks thereafter		<input type="checkbox"/> Starter Dose (3 SYR) <input type="checkbox"/> Maintenance Dose (2 SYR)	
Simponi®	<input type="checkbox"/> 100mg/1ml SmartJect Autoinjector <input type="checkbox"/> 100mg/1ml Prefilled SYR <input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled SYR	<input type="checkbox"/> Inject 100mg SC ONCE a month <input type="checkbox"/> Inject 50mg SC ONCE a month		<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Skyrizi	<input type="checkbox"/> 75 mg/0.83 ml prefilled syringe	Loading Dose: <input type="checkbox"/> Inject 150 mg (2-75mg syringes) SC at weeks 0, 4 and every 12 weeks thereafter	Maintenance Dose: <input type="checkbox"/> Inject 150 mg SC every 12 weeks	<input type="checkbox"/> 2 prefilled syringes	
Stelara®	<input type="checkbox"/> 45mg/0.5ml Prefilled SYR <input type="checkbox"/> 90mg/ml Prefilled SYR	<input type="checkbox"/> Patients weighing ≤100kg : Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter <input type="checkbox"/> Patients weighing >100kg: Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter		<input type="checkbox"/> 2 SYR (loading) <input type="checkbox"/> 1 SYR (maintenance)	
Taltz®	<input type="checkbox"/> 80mg/ml single-dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml single-dose Prefilled SYR	Loading Dose: <input type="checkbox"/> Inject 160mg SC at week 0 followed by 80mg SC on weeks 2, 4, 6, 8, 10 and 12	Maintenance Dose: <input type="checkbox"/> Inject 80mg SC every 4 weeks	<input type="checkbox"/> 3 syringes/pens <input type="checkbox"/> 2 syringes/pens <input type="checkbox"/> 1 syringe/pen	
Tremfya®	<input type="checkbox"/> 100mg/ml Prefilled SYR <input type="checkbox"/> 100 mg/ml prefilled autoinjector	<input type="checkbox"/> Inject _____ mg at weeks 0, 4, then every 8 weeks thereafter		<input type="checkbox"/> 4 week supply (loading) <input type="checkbox"/> 8 week supply (maintenance)	
Other					
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration			

Physician Signature: _____ Date: _____