

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Male Female
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

L20.89 Atopic Dermatitis
 L73.2 Hidradenitis
 L40.0 Moderate to Severe Plaque Psoriasis
 M06.9 Rheumatoid
 Other: _____

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

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Length of Treatment: _____
Reason for Discontinuation: _____

PHOTOTHERAPY UVA/UVB Failed:
Length of Treatment: _____
Reason for Discontinuation: _____

Patient Cannot Afford Photosensitivity Risk of skin cancer Distance from office

TB/PPD test: Positive Negative Date Read: _____
Location: Hands Feet Scalp Groin Face
 Nails Other: _____

American Academy Of Dermatology Consensus Statement On Psoriasis Therapies

Psoriasis is covering greater than 10% body surface area
 Psoriasis is on palms, soles, head & neck, or genitals
 Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
 Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment, or interpersonal relationships

Scoring Tool BSI EASI SCORAD POEM ISGA % or SCORE _____

Weight: _____ kg lbs Height: _____ cm in %BSA: _____
Allergies: _____ NKDA

Injection Training/Home Health RN visit is necessary. Yes No
 Home MD Office Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Refills:
<input type="checkbox"/> Humira® Citrate Free	<input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every other week (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)	
	<input type="checkbox"/> HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	ADULT: <input type="checkbox"/> INITIAL: Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week (Quantity: 4)	
	<input type="checkbox"/> Adolescent HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	ADOLESCENT: 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 day 29 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week (Quantity: 4) **Intended for weight > 60 kg/132 lbs*** _____	
<input type="checkbox"/> Humira®	<input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every other week (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)	
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Prescriber Signature: _____ **Date:** _____