

Please cut along the dotted lines before submitting to a pharmacy.

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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	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	PATIENT INFORMATION
☐ L20.89 Atopic Dermatitis ☐ L73.2 Hidradenitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ Other: _____ Prior Medication Failed: _____ Length of Treatment: _____ Reason for Discontinuation: _____	TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____ Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____ Allergies: _____ ☐ NKDA Injection Training/Home Health RN visit is necessary: ☐ Yes ☐ No Site of Care: ☐ Home ☐ MD Office ☐ Other: _____

PRESCRIPTION INFORMATION				
Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SUBQ at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	
☐ Cosentyx®	☐ 300mg (2x150) Pen ☐ PFS ☐ 150mg Pen ☐ PFS ☐ 300mg Pen	☐ Load: Inject ☐ 300mg or ☐ 150mg SUBQ week 0,1,2,3,4 ☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SUBQ every 4 weeks	5 week supply 4 week supply	
☐ Dupixent®	☐ 300mg per 2mL PFS ☐ 300mg per 2mL PFP	☐ Inject 600mg (two 300mg injections in different injection sites) SUBQ on day 0, then 300mg every other week ☐ Inject 300mg SUBQ every other week	1 month supply	
☐ Enbrel®	☐ 50mg Sureclick ☐ 25mg Vials ☐ 50mg PFS ☐ 25mg PFS	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg twice weekly	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS ☐ 80mg Pen ☐ 80mg PFS	☐ Inject 40mg SUBQ once a week ☐ Inject 80mg SUBQ every other week ☐ Inject 40mg SUBQ every other week ☐ Inject 80mg day 1, then 40mg day 8, then 40mg every other week ☐ Inject 160mg day 1, then day 15 inject 80mg, then starting day 29 inject 40mg every week ☐ Inject 160mg day 1, then day 15 inject 80mg, then starting day 29 inject 80mg every other week	1 month supply	
☐ Otezla®	☐ 30mg Tablet ☐ Starter Pack ☐ 70mg XR Tablet	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily ☐ Starter Pack: Take 1 tablet by mouth day 1, then take 1 tablet by mouth twice daily as directed	1 month supply	
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SUBQ once monthly	1 month supply	
☐ Stelara®	☐ 45 mg (1 x 45mg Vial) ☐ 90mg Vial (2 x 45mg Vials)	☐ Inject 45mg SUBQ at 0 and 4 weeks, and then every 12 weeks thereafter ☐ Inject 45mg SUBQ every 12 weeks ☐ Inject 90mg SUBQ at 0 and 4 weeks, and then every 12 weeks thereafter ☐ Inject 90mg SUBQ every 12 weeks	1 month supply	
☐ Tremfya®	☐ 100mg PFS ☐ 100mg PFP	☐ Inject 100mg SUBQ on week 0 and week 4 ☐ Inject 100mg SUBQ every 8 weeks	1 month supply	
☐ Other:				

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____



The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by faxing back to the originator.