

DERMATOLOGY

PATIENT INFORMATION

Name:		SSN:	DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Email:	Height:	Weight:
				Gender: Female Male

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Primary Diagnosis: Moderate to Severe Plaque Psoriasis Psoriatic Arthritis Hidradenitis Suppurativa Atopic Dermatitis Alopecia Areata Prurigo Nodularis Other: _____

Diagnosis Code (ICD-10): _____ Date of Diagnosis: _____ TB Test Completed On: _____ BSA: _____ Latex Allergy: Y N

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

<p>ADBRY™ (tralokinumab-ldm) 150 mg PFS <input type="checkbox"/> Induction: Inject 600 mg (4 x 150 mg) SUBQ Qty: 4 Refills: None Maintenance: <input type="checkbox"/> Inject 300 mg (2 x 150 mg) SUBQ every other week <input type="checkbox"/> Inject 300 mg (2 x 150 mg) SUBQ every 4 weeks <input type="checkbox"/> ADBRY™ Bridge Care™ Program: Inject 300 mg (2 x 150 mg) SUBQ every other week, starting on Day 15 Qty: _____ Refills: _____</p> <p>AMJEVITA™ (adalimumab-atto) PFS <input type="checkbox"/> SureClick 40 mg/0.8 mL <input type="checkbox"/> PFS 20 mg/0.4 mL <input type="checkbox"/> PFS 40 mg/0.8 mL <input type="checkbox"/> Induction: Inject 2 x 40 mg SUBQ <input type="checkbox"/> Maintenance: 40 mg every other week starting 1 week after initial dose Qty: _____ Refills: _____</p> <p>BIMZELX® (bimekizumab-bkxz) 160 mg PFS <input type="checkbox"/> Bridge* <input type="checkbox"/> Induction: Inject 320 mg (2 x 160 mg) SUBQ at week 0, 4, 8, 12, and 16 Qty: 10 syringes Refills: _____ <input type="checkbox"/> Maintenance: Inject 320 mg (2 x 160 mg) SUBQ every 8 weeks Qty: 2 syringes Refills: _____</p> <p>CIBINQO™ (abrocitinib) tablet <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> ____ mg PO once daily Qty: _____ Refills: _____</p> <p>Cimzia® (certolizumab pegol) PFS <input type="checkbox"/> Induction: Inject 2 x 200 mg/mL SUBQ at week 0, 2, and 4 Qty: 6 syringes Refills: 0 Maintenance: <input type="checkbox"/> 2 x 200 mg SUBQ every 4 weeks <input type="checkbox"/> 2 x 200 mg SUBQ every 2 weeks <input type="checkbox"/> 200 mg SUBQ every 2 weeks Qty: 28 days Refills: _____</p> <p>COSENTYX® (secukinumab) 75 mg <input type="checkbox"/> PFS <input type="checkbox"/> Induction: Inject 300 mg (2 x 150 mg/mL) SUBQ week 0, 1, 2, 3, 4 Qty: 10 Refills: 0 <input type="checkbox"/> Maintenance: Inject 300 mg SUBQ every 4 weeks Qty: 28 days Refills: _____ 150 mg <input type="checkbox"/> 150 mg Sensoready® Pen Kit <input type="checkbox"/> 150 mg PFS <input type="checkbox"/> Induction: Inject 150 mg SUBQ week 0, 1, 2, 3, 4 Qty: 5 Refills: _____ <input type="checkbox"/> Maintenance: Inject 150 mg SUBQ every 4 weeks Qty: 28 days Refills: _____ 300 mg <input type="checkbox"/> UnoReady Pen (1 x 300 mg/2 mL) <input type="checkbox"/> Sensoready® Pen Kit (2 x 150 mL) <input type="checkbox"/> PFS (2 x 150 mL) <input type="checkbox"/> Induction: Inject 300 mg SUBQ week 0, 1, 2, 3, 4 Qty: 10 Refills: 0 <input type="checkbox"/> Maintenance: Inject 300 mg SUBQ every 4 weeks Qty: 28 days Refills: _____</p> <p>DUPIXENT® (dupilumab) <input type="checkbox"/> PFS <input type="checkbox"/> pen <input type="checkbox"/> Induction: Inject 2 x 300 mg (600 mg) SUBQ Day 1 Qty: 2 for 14 days Refills: None <input type="checkbox"/> Maintenance: Inject 300 mg SUBQ every other week Qty: 2 for 28 days Refills: _____</p>	<p>EBGLYSS™ (lebrikizumab-ibkz) <input type="checkbox"/> pen <input type="checkbox"/> Initial: Inject 500 mg (2 x 250 mg) SUBQ at week 0 and 2 Qty: 4 pens Refills: None <input type="checkbox"/> Induction: Inject 250 mg SUBQ every 2 weeks (weeks 4-14) Qty: 2 pens Refills: 2 <input type="checkbox"/> Maintenance: Inject 250 mg SUBQ every 4 weeks starting week 16 Qty: 1 pen Refills: _____</p> <p>ENBREL® (etanercept) <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector <input type="checkbox"/> Vial <input type="checkbox"/> Induction: Inject (50 mg) SUBQ twice weekly for three months Qty: 8 Refills: 2 Maintenance: <input type="checkbox"/> 50 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> Once weekly SUBQ <input type="checkbox"/> Twice weekly SUBQ Qty: <input type="checkbox"/> 8 <input type="checkbox"/> 4 Refills: _____</p> <p>ERIVEDGE™ (vismodegib) <input type="checkbox"/> 150 mg capsule once daily PO, with or without food Qty: 28 days Refills: _____</p> <p>HUMIRA® (adalimumab) <input type="checkbox"/> pen <input type="checkbox"/> PFS <input type="checkbox"/> citrate free (CF) <input type="checkbox"/> original formula Hidradenitis Suppurativa Starter: <input type="checkbox"/> 160 mg SUBQ day 1, 80 mg SUBQ day 15 <input type="checkbox"/> 80 mg SUBQ day 1, 80 mg SUBQ day 2, 80 mg SUBQ day 15 <input type="checkbox"/> Psoriasis Starter: 80 mg SUBQ day 1, 40 mg SUBQ day 8, 40 mg SUBQ day 22 Qty: 1 Pack Refills: 0 Hidradenitis Suppurativa Maintenance: <input type="checkbox"/> 40 mg SUBQ once weekly, beginning day 29 <input type="checkbox"/> 80 mg SUBQ every other week, beginning day 29 <input type="checkbox"/> Psoriasis Maintenance: 40 mg SUBQ every other week Qty: 28 days Refills: _____</p> <p>ILUMYA™ (tildrakizumab-asnm) PFS <input type="checkbox"/> Induction: Inject 100 mg/mL SUBQ at weeks 0 and 4 Qty: 2 Refills: None <input type="checkbox"/> Maintenance: Inject 100 mg/mL SUBQ every 12 weeks Qty: _____ Refills: _____</p> <p>INFLECTRA® (infliximab-dyyb) 100 mg vials <input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> Induction: Give dose as an IV infusion at 0, 2, and 6 weeks Qty: _____ Refills: 2 <input type="checkbox"/> Maintenance: Give dose as an IV infusion every ____ weeks Qty: _____ Refills: 2</p> <p>LITFULO™ (ritlektinib) capsule <input type="checkbox"/> 50 mg PO once daily Qty: 28 Refills: _____</p> <p>NEMLUVIO® (nemolizumab-ilt) PFS <input type="checkbox"/> 30 mg/mL <input type="checkbox"/> Induction: Inject 60 mg/mL (2 x 30 mg/mL) SUBQ Qty: 2 Refills: None <input type="checkbox"/> Maintenance: Inject 30 mg/mL SUBQ every 4 weeks Qty: _____ Refills: _____</p> <p>ODOMZO® (sonidegib) capsule <input type="checkbox"/> 200 mg on an empty stomach, at least 1 hr before or 2 hrs after a meal Qty: 30 Refills: _____</p> <p>OLUMIANT® (baricitinib) tablet <input type="checkbox"/> 2 mg PO once daily <input type="checkbox"/> 4 mg PO once daily Qty: _____ Refills: _____</p> <p>OPZELURA® (roxolitinib) cream <input type="checkbox"/> 1.5% cream 60 gram tube Qty: ____ tubes Refills: 0 Qty: 28 day supply</p>	<p>OTEZLA® (apremilast) <input type="checkbox"/> Titration Pack: PO as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Bridge Pack: PO as directed per package instructions Qty: 1 Pack Refills: _____ <input type="checkbox"/> Maintenance: (30 mg) PO twice daily Qty: 30 days Refills: _____</p> <p>REMICADE® (infliximab) 100 mg vial <input type="checkbox"/> Biosimilar authorized <input type="checkbox"/> Induction: 5 mg/kg as an IV infusion at 0, 2, and 6 weeks Qty: 1 dose Refills: 2 <input type="checkbox"/> Maintenance: 5 mg/kg as an IV infusion every 8 weeks Qty: _____ Refills: _____</p> <p>RINVOQ® (upadacitinib) extended-release tablet <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Once daily PO with or without food Qty: _____ Refills: _____</p> <p>SILIQ® (brodalumab) PFS <input type="checkbox"/> Induction: Inject 210 mg SUBQ weeks 0 and 1 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: Starting at Week 2 of therapy, inject 210 mg SUBQ every 2 weeks Qty: 2 Refills: _____</p> <p>SIMPONI® (golimumab) <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector <input type="checkbox"/> Inject 50 mg SUBQ once a month Qty: 1 Refills: _____</p> <p>SKYRIZI™ (risankizumab-rzaa) <input type="checkbox"/> PFS <input type="checkbox"/> pen <input type="checkbox"/> Inject 150 mg (1 injection) SUBQ at Week 0, Week 4 Qty: 2 syringes Refills: _____ <input type="checkbox"/> Maintenance: Inject 150 mg SUBQ every 12 weeks Qty: _____ Refills: _____</p> <p>STELARA® (ustekinumab) <input type="checkbox"/> 45 mg PFS <input type="checkbox"/> 90 mg PFS <input type="checkbox"/> Induction: Inject contents of 1 syringe SUBQ on day 0 and day 28 Qty: 1 syringe Refills: 1 <input type="checkbox"/> Maintenance: Inject contents of 1 syringe SUBQ every 12 weeks Qty: 1 syringe Refills: _____</p> <p>SOTYKTU™ (deucravacitinib) 6 mg tablet <input type="checkbox"/> Once daily PO with or without food Qty: _____ Refills: _____</p> <p>TALTZ® (ixekizumab) <input type="checkbox"/> citrate free (CF) <input type="checkbox"/> Autoinjector <input type="checkbox"/> PFS <input type="checkbox"/> Psoriasis Induction: Inject 160 mg (2 x 80 mg) SUBQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8, 10, 12 Qty: 8 Refills: 0 <input type="checkbox"/> Psoriatic Arthritis Induction: Inject 160 mg (2 x 80 mg) SUBQ at week 0 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: 80 mg SUBQ every 4 weeks Qty: 1 Refills: _____</p> <p>TREMFYA® (guselkumab) <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector <input type="checkbox"/> Induction: Inject 100 mg SUBQ weeks 0 and 4 Qty: 1 Refills: 1 <input type="checkbox"/> Maintenance: Inject 100 mg SUBQ every 8 weeks Qty: 1 Refills: _____</p> <p><input type="checkbox"/> OTHER</p> <p>STRENGTH: _____</p> <p>SIG/DIRECTIONS: _____</p> <p>QUANTITY: _____ REFILLS: _____</p>
--	--	--

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PHYSICIAN INFORMATION

Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	City:	State: ZIP:
NPI #:	Tax ID#:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office
Prescriber Signature:	Date:	