

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Central Pharmacy: _____ Pharmacy Phone: _____
Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____
Date Needed: _____ Ship To: [] Prescriber's Office [] Patient's Home [] Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ [] Male [] Female
Address: _____ City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____
Insurance provider (Please include copy of front and back of card): _____
ID #: _____ Policy/Group #: _____ Phone #: _____ [] Patient is eligible for Medicare
Name of Insured: _____ Employer: _____
Relationship to Patient: [] Self [] Other: _____ Prescription Card: [] Yes [] No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT - Please complete ALL sections to avoid delays in filling prescription

[] Patient is new to therapy [] Patient is currently on therapy Start date: _____
Primary Diagnosis Code and Condition (ICD-10): _____ Date of Diagnosis/Years with Disease: _____
% BSA affected by Psoriasis Severity: [] Moderate [] Moderate to Severe [] Severe Number of tender/swollen joints: _____ TB Test Result: _____ Date: _____
[] Inadequate Response to Standard Systemic Agents [] Inadequate Response to Standard Phototherapy Current Weight: _____ Date: _____
Allergies: _____

MEDICATIONS

Cimzia (certolizumab pegol)
[] Starter Kit 6x200mg Prefilled Syringes
Qty: _____ Refills: _____
Directions: _____
[] 2x200mg Vials
[] 2x200mg Prefilled Syringes
Qty: _____ Refills: _____
Directions: _____

Cosentyx (secukinumab)
[] 150mg Pen
[] 150mg Prefilled Syringe
[] 2X150mg Pack (300mg) Pen
[] 2X150mg Pack (300mg) Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____

Dupilumab (dupilumab)
[] 200mg Prefilled Syringe with Needle Shield
[] 300mg Prefilled Syringe with Needle Shield
Qty: _____ Refills: _____
Directions: _____

Enbrel (etanercept)
[] 25mg Prefilled Syringe
[] 25mg Vial
[] 50mg Prefilled Syringe
[] 50mg SureClick™ Pen
[] 50mg Mini™ Cartridge
Qty: _____ Refills: _____
Directions: _____

Humira (adalimumab)
[] 4x40mg Pens - Psoriasis Starter Kit
[] 6x40mg Pens - Hidradenitis Suppurativa Starter Kit
Qty: _____ Refills: _____
Directions: _____
[] 40mg/0.8ml Prefilled Syringes
[] 40mg/0.8ml Pens
[] Other: _____
Qty: _____ Refills: _____
Directions: _____

Humira citrate free (adalimumab)
[] 80mg/0.8ml & 40mg/0.4ml Psoriasis citrate free Starter Kit
[] 80mg/0.8ml - Hidradenitis suppurativa citrate free Starter Kit
Qty: _____ Refills: _____
Directions: _____
[] 40mg/0.4ml citrate free Prefilled Syringes
[] 40mg/0.4ml citrate free Pens
Qty: _____ Refills: _____
Directions: _____

Ilumya (tildrakizumab-asmn)
[] 100mg/ml Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____

Inflectra (infliximab-dyyb)
[] 100mg Vial
Qty: _____ Refills: _____
Directions: _____

Orencia (abatacept)
[] 250mg Vial
[] 125mg Prefilled Syringe
[] 125mg Clickjet Pen
Qty: _____ Refills: _____
Directions: _____

Otezla (apremilast)
[] Titration Pack
Qty: _____ Refills: _____
Directions: _____
[] 30mg Tablets
Qty: _____ Refills: _____
Directions: _____

Remicade (infliximab)
[] 100mg Vial
Qty: _____ Refills: _____
Directions: _____

Renflexis (infliximab-abda)
[] 100mg vial
Qty: _____ Refills: _____
Directions: _____

Siliq (brodalumab)
[] 210mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____

Simponi (golimumab)
[] 50mg SmartJect™ Autoinjector
[] 50mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____

Simponi Aria (golimumab)
[] 50mg Vial
Qty: _____ Refills: _____
Directions: _____

Skyrizi
[] 2x75mg/0.83ml single-dose prefilled syringe
Qty: _____ Refills: _____
Directions: _____

Stelara (ustekinumab)
[] 45mg Prefilled Syringe
[] 45mg Single-dose Vial
[] 90mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____

Taltz (ixekizumab)
[] 80mg Prefilled Syringe
[] 80mg Autoinjector
Qty: _____ Refills: _____
Directions: _____

Tremfya (guselkumab)
[] 100mg/ml One-Press Patient-Controlled Injector
[] 100mg/ml Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____

Xeljanz
[] 5mg tablets
[] 11mg XR tablets
Qty: _____ Refills: _____
Directions: _____
[] Other: _____
Qty: _____ Refills: _____
Directions: _____

Methotrexate - Can only be ordered with other specialty meds. [] 2.5mg Tablet Directions: _____ Qty: _____ Refills: _____

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: [] Email [] Phone [] Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written Substitution permitted Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.