

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

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).

Dermatology
Prescription/Pharmacy Intake Form

Pharmacy: _____ 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

Adby (tralokinumab-ldrm)
 150mg 2 cartons (4 prefilled syringes)
 150mg 1 carton (2 prefilled syringes)
Qty: _____ Refills: _____
Directions: _____
Amjevita (adalimumab-atto)
 Single-dose prefilled SureClick autoinjector: 40 mg/0.8 mL
 Single-dose prefilled syringe: 20 mg/0.4 mL
 Single-dose prefilled syringe: 40 mg/0.8 mL
Qty: _____ Refills: _____
Directions: _____
Avsola (infliximab-axxq)
 100 mg vials
Qty: _____ Refills: _____
Directions: _____
Cibinqo (abrocitinib)
 50mg Tablets 100mg Tablets 200mg Tablets
Qty: _____ Refills: _____
Directions: _____
Cimzia (certolizumab pegol)
 Starter Kit 6x200mg Prefilled Syringes
Qty: _____ Refills: _____
Directions: _____
 2x200mg Vials 2x200mg Prefilled Syringes
Qty: _____ Refills: _____
Directions: _____
Cosentyx (secukinumab)
 75mg Prefilled Syringe
 150mg Pen
 150mg Prefilled Syringe
 2X150mg Pack (300mg) Pen
 2X150mg Pack (300mg) Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____
Dupixent (dupilumab)
 200mg Prefilled Syringe with Needle Shield
 300mg Prefilled Syringe with Needle Shield
 200mg Pen
 300mg Pen
Qty: _____ Refills: _____
Directions: _____
Enbrel (etanercept)
 25mg Prefilled Syringe
 25mg Vial
 50mg Prefilled Syringe
 50mg SureClick™ Pen
 50mg Mini™ Cartridge
Qty: _____ Refills: _____
Directions: _____

Humira (adalimumab)
 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
 80mg/0.8ml citrate free Pens
Qty: _____ Refills: _____
Directions: _____
Ilumya (tildrakizumab-asmn)
 100mg/ml Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____
Inflectra (infliximab-dyyb)
 100mg Vial
Qty: _____ Refills: _____
Directions: _____
Litfulo
 50mg Capsules
Qty: _____ Refills: _____
Directions: _____
Olumiant (baricitinib)
 2mg Tablets 4mg Tablets
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: _____

Rinvoq (upadacitinib)
 15mg Tablets 30mg Tablets
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 (risankizumab-rzaa)
 150mg Pen 150mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: _____
 Sotyku (deucravacitinib) 6mg Tablets
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: _____
 Other: _____
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.

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Drug names are the property of their respective owners.