Longs
SPECIALTY PHARMACY

# DERMATOLOGY A-N

phone 866.437.6717 fax 866.550.7421
1216 West Main St. • Lexington, SC 29072 **longsrx.com**

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name | | |
| Address | | |
| City | State | Zip |
| Main Phone | Alternative Phone | ❑ Male ❑ Female |
| Social Security # | | Date of Birth |

## PRESCRIBER INFORMATION

| | | |
|---|---|---|
| Prescriber Name | | |
| Prescriber Type | ❑ Physician (MD or DO) ❑ Nurse Practitioner | ❑ Physician's Assistant |
| Supervising Physician (If prescriber is a NP or PA) | | |
| DEA # | NPI # | Tax ID # |
| Address | | |
| City | State | Zip |
| Phone | Fax | |
| Contact Person | | |

**INSURANCE:** PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

| PRESCRIPTION INFORMATION | | | QUANTITY | REFILLS |
|---|---|---|---|---|
| ❑ Cimzia® | ❑ Prefilled Syringe<br>❑ Vials | ❑ **INITIAL:** Inject 400 mg SQ at weeks 0, 2, and 4<br>❑ **PSORIATIC MAINTENANCE:** Inject 200 mg SQ every 2 weeks **OR** ❑ Inject 400 mg SQ every 4 weeks<br>❑ **PSORIASIS MAINTENANCE:** Inject 400 mg SQ every 2 weeks **OR** ❑ Inject 200 mg SQ every 2 weeks (≤ 90kg) | 1 Starter Kit<br>4 Week Supply | _____ |
| ❑ Cosentyx® | ❑ SensorReady Pen<br>❑ Prefilled Syringe | ❑ **INITIAL:** Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5)<br>❑ **INITIAL:** Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10)<br>❑ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty 1)<br>❑ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty 2) | | _____ |
| ❑ Cosentyx® *Covered Until You're Covered* | ❑ SensorReady Pen<br>❑ Prefilled Syringe | ❑ **INITIAL:** Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5)<br>❑ **INITIAL:** Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10)<br>❑ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty 1)<br>❑ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty 2) | | _____ |
| ❑ Dupixent® | 300mg/2mL Syringe - 2 Pack | ❑ **INITIAL:** Inject 600mg SQ at day 1.<br>Starting on day 15, inject 300mg every other week<br>❑ **MAINTENANCE:** 300mg every other week | Loading Dose<br>4 Week Supply | _____ |
| ❑ Enbrel® | ❑ Sureclick Pen<br>❑ Mini with AutoTouch<br>❑ Pre-filled Syringe<br>❑ 25mg ❑ 50mg<br>❑ Vials 25mg | ❑ **INITIAL:** Inject 50 mg SQ TWICE a week 72-96 hours apart<br>❑ **MAINTENANCE:** Inject 50 mg SQ ONCE a week<br>❑ **MAINTENANCE:** Inject 25 mg SQ TWICE a week 72-96 hours apart | 4 Week Supply | 2<br>_____ |
| ❑ **Humira®** ***Citrate Free*** | ❑ Psoriasis Starter Kit<br>❑ Pen ❑ Prefilled Syringe | ❑ **INITIAL:** Inject 80mg SQ on day 1, 40mg on day 8, then 40mg every **other** week<br>❑ **MAINTENANCE:** Inject 40 mg SQ **every other** week | 3<br>2 | _____ |
| | ❑ HS Starter Kit<br>❑ Pen ❑ Prefilled Syringe | ❑ **INITIAL:** Inject 160mg SQ on day 1, 80mg on day 15<br>❑ **MAINTENANCE:** Inject 40mg SQ **every week** | 3<br>4 | _____ |
| ❑ Humira® | ❑ Psoriasis Starter Kit<br>❑ Pen ❑ Prefilled Syringe | ❑ **INITIAL:** Inject 80mg SQ on day 1, 40mg on day 8, then 40mg every **other** week<br>❑ **MAINTENANCE:** Inject 40mg SQ **every other** week | 4<br>2 | _____ |
| | ❑ HS Starter Kit<br>❑ Pen ❑ Prefilled Syringe | ❑ **INITIAL:** Inject 160mg SQ on day 1, 80mg on day 15<br>❑ **MAINTENANCE:** Inject 40mg SQ **every week** | 6<br>4 | _____ |
| ❑ Ilumya™ | 100 mg Pre-filled syringe | ❑ **INITIAL:** Inject 100 mg SQ at week 0 and week 4<br>❑ **MAINTENANCE:** Inject 100 mg SQ every 12 weeks thereafter | 1<br>1 | 1<br>_____ |

## CLINICAL INFORMATION

Diagnosis: ❑ L40.0 Moderate to Severe Plaque Psoriasis ❑ L40.50 Psoriatic Arthritis ❑ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
❑ Other: _____ DX Code: _____ ❑ L20.9 Atopic Dermatitis unspecified

Location: % BSA:_____ ❑ Hands ❑ Feet ❑ Scalp ❑ Groin ❑ Nails ❑ Other: _____ Patient Allergies:

Prior Failed Meds: ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Orencia ❑ Remicade ❑ Simponi ❑ Soriatane ❑ Stelara ❑ Taltz

**Methotrexate** Length of Treatment:_____ Reason for Discontinuing:_____
**PUVA/UVB** Length of Treatment:_____ Reason for Discontinuing:_____
**Topicals** Length of Treatment:_____ Reason for Discontinuing:_____
Contraindicated Medication:_____ Reason:_____
Inadequate Response (*List Specific Names*):_____

| | | | |
|---|---|---|---|
| Weight: | Height: | Hepatitis Test Result: | Hep B ruled out/treated: ❑ Yes ❑ No Date: |
| TB/PPD Test given? ❑ Yes ❑ No Test Date: | Test Results: | ISGA score: EASI score: | POEM score: SCORAD: |
| Additional Information: | | | |

**Dispense As Written** (no stamps) _____ **Date** _____ **Substitution Permitted** (no stamps) _____ **Date** _____

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.

SPLX4-3.1R1018
October 2018