Longs
SPECIALTY PHARMACY

DERMATOLOGY A-H

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

Drug	Form	Directions	QUANTITY	REFILLS
❏ Cimzia®	❏ Prefilled Syringe ❏ Vials	❏ **INITIAL:** Inject 400 mg SQ at weeks 0, 2, and 4 ❏ **PSORIATIC MAINTENANCE:** Inject 200 mg SQ every 2 weeks **OR** ❏ Inject 400 mg SQ every 4 weeks ❏ **PSORIASIS MAINTENANCE:** Inject 400 mg SQ every 2 weeks **OR** ❏ Inject 200 mg SQ every 2 weeks (≤ 90kg)	1 Starter Kit 4 Week Supply	________
❏ Cosentyx®	❏ SensorReady Pen ❏ Prefilled Syringe	❏ **INITIAL:** Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) ❏ **INITIAL:** Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10) ❏ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty 1) ❏ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty 2)		________
❏ Cosentyx® *Covered Until You're Covered*	❏ SensorReady Pen ❏ Prefilled Syringe	❏ **INITIAL:** Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) ❏ **INITIAL:** Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10) ❏ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty 1) ❏ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty 2)		________
❏ Dupixent®	***18 + years OR 12-17 yrs ≥ 60 kg*** 300mg/2mL Syringe - 2 Pack	❏ **INITIAL:** Inject 600 mg SQ at day 1. Starting on day 15, inject 300 mg every other week ❏ **MAINTENANCE:** 300mg every other week	Loading Dose 4 Week Supply	________
❏ Dupixent®	***12-17 yrs < 60 kg*** 200 mg/ 1.14 ml Syringe	❏ **INITIAL:** Inject 400 mg SC at day 1. Starting on day 15, inject 200 mg every other week ❏ **MAINTENANCE:** Inject 200 mg every other week	Loading Dose 4 Week Supply	________
❏ Enbrel®	❏ Sureclick Pen ❏ Vials 25mg ❏ Mini with AutoTouch Pre-filled Syringe ❏25mg❏50mg	❏ **INITIAL:** Inject 50 mg SQ TWICE a week 72-96 hours apart ❏ **MAINTENANCE:** Inject 50 mg SQ ONCE a week ❏ **MAINTENANCE:** Inject 25 mg SQ TWICE a week 72-96 hours apart	4 Week Supply	2 ________
❏ **Humira®** ***Citrate Free***	❏ Psoriasis Starter Kit ❏ Pen ❏ Prefilled Syringe	❏ **INITIAL:** Inject 80mg SQ on day 1, 40mg on day 8, then 40mg every **other** week ❏ **MAINTENANCE:** Inject 40 mg SQ **every other** week	3 2	________
	❏ HS Starter Kit ❏ Pen ❏ Prefilled Syringe	❏ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting on day 29 ❏ **MAINTENANCE:** Inject 40mg SQ **every week**	3 4	________
	❏ Adolescent HS Starter Kit ❏ Pen ❏ Prefilled Syringe **weight required:** __________	❏ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting on day 29 ❏ **MAINTENANCE:** Inject 40 mg SQ **every week** ***** Intended for weight ≥ 60 kg**	3 4	0 ________
		❏ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg **every other** week ❏ **MAINTENANCE:** Inject 40 mg SQ **every other** week *****Intended for weight 30 kg to <60kg**	3 2	0 ________

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.

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