

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	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #		Date of Birth	

PRESCRIBER INFORMATION			
Prescriber Name			
Prescriber Type	<input type="checkbox"/> Physician (MD or DO)	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> 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
<input type="checkbox"/> Ilumya™	100 mg Pre-filled syringe	<input type="checkbox"/> INITIAL: Inject 100 mg SQ at week 0 and week 4 <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 12 weeks thereafter	1 1	1 _____
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Titrate: Take 1 tablet on day 1 then twice daily as directed OR date provided _____ <input type="checkbox"/> Maintenance: Take 1 tablet by mouth ONCE daily <input type="checkbox"/> Maintenance: Take 1 tablet by mouth TWICE daily.	1 Starter Pack 30 60	_____
<input type="checkbox"/> Otezla® <i>Bridge Rx</i>	30mg Tablets	<input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth TWICE daily; dispensed by OSP (Recommended daily dose) ***Starter Pack Provided Date: _____ <input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth ONCE daily; dispensed by OSP (For Patients with severe renal impairment)	28	6 12
<input type="checkbox"/> Siliq™	210mg Pre-filled Syringe	<input type="checkbox"/> Initial: Inject 210 mg SQ on weeks 0, 1, and 2 <input type="checkbox"/> Maintenance: Inject 210 mg SQ every 2 weeks starting at week 4	3 4 Week Supply	0 _____
<input type="checkbox"/> Skyrizi™	75 mg Pre-filled Syringe	<input type="checkbox"/> Initial: Inject 150 mg (2 syringes) SQ at weeks 0 & 4 <input type="checkbox"/> Maintenance: Inject 150 mg (2 syringes) SQ every 12 weeks	1 box (2 syringes) 1 box (2 syringes)	1 _____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg Pre-filled Syringe <input type="checkbox"/> 90mg Pre-filled Syringe Weight Required: _____	<input type="checkbox"/> Inject 45mg on day 0, then week 4, then every 12 weeks (Patients ≤ 220lbs) <input type="checkbox"/> Inject 90mg on day 0, then week 4, then every 12 weeks (Patients > 220lbs)	4 Week Supply	_____
<input type="checkbox"/> Tremfya™	<input type="checkbox"/> One- Press Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Initial: Inject 100 mg SQ at week 0 and then at week 4 <input type="checkbox"/> Maintenance: Inject 100 mg SQ every 8 weeks	1 1	1 _____
<input type="checkbox"/> Taltz®	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> Starting: Inject 160 mg SQ on day 1, then begin first induction dose 2 weeks later (week 2) <input type="checkbox"/> Induction: Inject 80 mg SQ every 2 weeks (weeks 4-10) <input type="checkbox"/> Final Induction Dose: Inject 80 mg SQ on week 12 <input type="checkbox"/> Maintenance: Inject 80 mg SQ every 4 weeks (thereafter)	3 2 1 1	0 1 0 _____
<input type="checkbox"/> Taltz® <i>Psoriatic Arthritis Only</i>	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Initial: Inject 160 mg SQ on week 0 <input type="checkbox"/> Maintenance: Inject 80 mg SQ every 4 weeks	2 1	_____

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.