



Dermatology Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name: _____ DOB: _____
 SSN: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____
 Known Allergies: _____
 Height: _____ Weight: _____ lbs. M F
 Emergency Contact: _____
 Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
 City, State: _____
 ID Number: _____
 Group Number: _____ Rx Bin: _____
 Secondary Insurance: _____
 City, State: _____
 ID Number: _____
 Group Number: _____ Rx Bin: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ License: _____ DEA: _____
 Address: _____ City, State, Zip: _____
 Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

Psoriasis Hidradenitis Suppurativa Dermatitis Other: _____
 ICD-10: _____
 Prior Failed Therapies: _____ Reason For Discontinuation: _____

MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
<input type="checkbox"/> Bexarotene	<input type="checkbox"/> 75mg capsules <input type="checkbox"/> 1% gel			
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 75mg/0.5mL <input type="checkbox"/> 150mg <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject SC at weeks 0, 1, 2, 3 and 4, followed by SC every 4 weeks <input type="checkbox"/> Maintenance Dose: Inject SC every 4 weeks (maintenance) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300mg/2mL <input type="checkbox"/> 200mg/1.14mL <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> Starter Dose: 600mg SC divided in 2 different injection sites <input type="checkbox"/> Maintenance Dose: 300mg SC every other week <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 50mg/ml SureClick™ Autoinjector <input type="checkbox"/> 50mg/ml Mini Cartridge <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe <input type="checkbox"/> 25mg/0.5ml Single Dose Vial	<input type="checkbox"/> Starter Dose: Inject 50mg SC TWICE a week (72-96 hours apart for three months) <input type="checkbox"/> Maintenance Dose: Inject 50mg SC ONCE a week <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Eucrisa®	<input type="checkbox"/> 60-g tube <input type="checkbox"/> 100-g tube	<input type="checkbox"/> Apply a thin layer twice daily to affected areas. For topical use only. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Humira	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe (2 doses) <input type="checkbox"/> 40mg/0.8ml Pen (2 doses) <input type="checkbox"/> CF 40mg/0.4ml Pen (2 doses) <input type="checkbox"/> CF 40mg/0.4ml Prefilled Syringe (2 doses) <input type="checkbox"/> Other _____	<input type="checkbox"/> Starter Dose: Hidradenitis Suppurativa: Inject 160mg SC in day 1, 80mg on day 15 <input type="checkbox"/> Starter Dose: Plaque Psoriasis: Inject 80mg SC day 1, 40mg on day 8, and 40mg every 2 wks. thereafter <input type="checkbox"/> Other: _____ <input type="checkbox"/> Maintenance Dose: Inject 40mg SC on day 29 and then every wk. thereafter <input type="checkbox"/> Maintenance Dose: Inject 40mg SC every 2 weeks		
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Titration Pack 10/20/30mg <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> 1 X 28 day pack (55 tablets) – Take as Directed on Starter Package <input type="checkbox"/> Maintenance Dose: take 30mg twice daily by mouth		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 45mg/0.5ml Single Dose Vial <input type="checkbox"/> 90mg/1ml Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 45mg SC (patient ≤100 kg) at Day 1 <input type="checkbox"/> Starter Dose: Inject 90mg SC (patient >100 kg) at Day 1 <input type="checkbox"/> Maintenance Dose: Inject 45mg SC (patient ≤100 kg) On Day 29 and then every 12 weeks <input type="checkbox"/> Maintenance Dose: Inject 90mg SC (patient >100 kg) On Day 29 and then every 12 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80mg/mL Autoinjector <input type="checkbox"/> 80mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: 160mg SC at week 0; then inject 80mg SC at weeks 2,4,6,8,10 & 12 <input type="checkbox"/> Maintenance Dose: 80mg SC every 4 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> 100mg/ml Prefilled Syringe <input type="checkbox"/> 100mg/ml Prefilled Pen	<input type="checkbox"/> Starter Dose: Inject 100mg SC at weeks 0 & 4 <input type="checkbox"/> Maintenance Dose: Inject 100mg SQ every 8 weeks		
<input type="checkbox"/> Other				

DELIVERY INFORMATION

Need by: _____ Deliver to: Patient's home MD Office/ Clinic Other: _____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: _____ DAW Date: _____