Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe ID # 3306986

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
☐Bexarotene	☐ 75mg capsules	☐ 1% gel			
☐Cosentyx®	☐ 300mg ☐ 150mg	☐ Sensoready Pen ☐ Prefilled Syringe	☐ **Starter Dose:** Inject SC at weeks 0, 1, 2, 3 and 4 ☐ **Maintenance Dose:** Inject SC every 4 weeks ☐ **Other:**__________		
☐Dupixent®	☐ 300mg/2mL Prefilled Syringe		☐ **Starter Dose:** 600mg SC divided in 2 different injection sites ☐ **Maintenance Dose:** 300mg SC every other week		
☐Enbrel®	☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Mini Cartridge ☐ 25mg/0.5ml Prefilled Syringe		☐ Starter Dose: Inject 50mg SC TWICE a week (72-96 hours apart for three months) ☐ Maintenance Dose: Inject 50mg SC ONCE a week ☐ **Other:**__________		
☐Eucrisa®	☐ 60-g tube		☐ Apply a thin layer twice daily to affected areas. For topical use only. ☐ **Other directions:**__________		
☐Humira	☐ 20mg/0.4ml Prefilled Syringe (2 doses) ☐ 40mg/0.8ml Pen (2 doses) ☐ 40mg/0.8ml Prefilled Syringe (2 doses) ☐ 40mg Kit 4x0.8ml ☐ 40mg Starter Kit 6x0.8ml		☐ **Starter Dose:** Hidradenitis Suppurativa: Inject 160mg SC in day 1, 80mg on day 15 ☐ **Starter Dose:** Plaque Psoriasis; Inject 80mg SC day 1, 40mg on day 8, and 40mg every 2 wks. thereafter ☐ **Other:**__________ ☐ **Maintenance Dose:** Hidradenitis Suppurativa: Inject 40mg SC on day 29 and then every wk. thereafter ☐ **Maintenance Dose:** Plaque Psoriasis; Inject 40mg SC every 2 weeks		
☐Kerydin®	☐ 5% solution		☐ Apply KERYDIN to affected toenails once daily for 48 weeks. ☐ **Other directions:**__________		
☐Otezla®	☐ Titration Pack 10/20/30mg ☐ 30mg		☐ 1 X 28 day pack (55 tablets) ☐ **Maintenance Dose:** take 30mg twice daily by mouth		
☐Stelara®	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/1ml Prefilled Syringe		☐ **Starter Dose:** Inject 45mg SC (patient ≤100 kg) at Day 1 ☐ **Starter Dose:** Inject 90mg SC (patient >100 kg) at Day 1 ☐ **Maintenance Dose:** Inject 45mg SC (patient ≤100 kg) On Day 29 and then every 12 weeks ☐ **Maintenance Dose:** Inject 90mg SC (patient >100 kg) On Day 29 and then every 12 weeks ☐ **Other:**__________		
☐Taltz®	☐ Autoinjector 80mg/mL ☐ Prefilled Syringe 80mg/mL		☐ **Starter Dose:** 160mg SQ at week 0; then inject 80mg SQ at weeks 2,4,6,8,10 & 12 ☐ **Maintenance Dose:** 80mg SQ every 4 weeks		
☐Tremfya®	☐ 100mg/ml Prefilled Syringe		☐ **Starter Dose:** Inject 100mg SC at weeks 0 & 4 ☐ **Maintenance Dose:** Inject 100mg SQ every 8 weeks		
☐Other					

DELIVERY INFORMATION

Need by: ____________ **Deliver to:** ☐ Patient's home ☐ MD Office/ Clinic ☐ Other:____________

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature:____________________ ☐ **DAW** **Date:** __________

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.