PREMIER PHARMACY SERVICES

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DERMATOLOGY RX ORDER FORM

Ship to: ☐ Patient ☐ Physician ☐ Other • **Need:** ☐ Nurse ☐ Training
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: _____ DOB: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____ Alt. Phone: _____
SS#: _____
Allergies: _____ Alternate Contact Info: _____

Prescription

Please attach copies of front and back of Patient's Prescription Insurance Cards and most recent labs.

Clinical:

Gender: ☐ M ☐ F
HT: _____
WT: _____
BSA: _____

DIAGNOSIS:
- ☐ L40.9 Psoriasis
- ☐ L40.52 Psoriatic Arthritis
- ☐ C43 Malignant Melanoma (Zelboraf)
- ☐ C44.91 Basal Cell Carcinoma (Erivedge)
- ☐ Other Diagnosis: ICD-10 Code

Description _____
_____
Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date _____
Review Date _____

Prescription:	Dose / Strength	Directions	Qty.	Refills:
☐ **Enbrel (Amgen)**	☐ 25mg/ml Vial ☐ 25mg/0.5ml Prefilled Syringe ☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml SureClick Autoinjector	For Psoriasis ☐ **Initial Dose:** Inject 50mg SQ twice weekly for 3 months ☐ **Maintenance:** Inject 50mg SQ weekly For Psoriatic Arthritis ☐ Inject 50mg SQ once weekly		
☐ **Erivedge**	☐ 150mg	☐ 1 tablet by mouth once daily		
☐ **Humira (Abbott)**	☐ Psoriasis Starter Package 40mg/0.8 Prefilled AutoPen ☐ 40mg/0.8 Prefilled Syringe	For Psoriasis ☐ **Initial Dose:** Inject 80mg SQ once on day 1, then 40mg on day 8, then 40mg every other week ☐ **Maintenance:** Inject 40mg SQ every other For Psoriatic Arthritis ☐ Inject 40mg SQ every other week		
☐ **Otezla (Celgene)**	☐ Titration Starter Pack ☐ 30mgTablet	☐ **Titration:** Day 1: 10mg PO in the morning Day 2: 10mg PO in the morning and 10mg PO in the evening Day 3: 10mg PO in the morning and 20mg PO in the evening Day 4: 20mg PO in the morning and 20mg PO in the evening Day 5: 20mg PO in the morning and 30mg PO in the evening ☐ **Maintenance:** 30mg tablet orally twice daily (starting day 6)		
☐ **Remicade**	☐ 100mg Vial	☐ **Initial dose:** Infuse 5mg/kg IV at week 0, 2 and 6 ☐ **Maintenance:** Infuse 5mg/kg IV every 8 weeks thereafter		
☐ **Simponi (Janssen)** ☐ Enroll in SimponiOne	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SQ once per month		
☐ **Stelara**	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/ml Prefilled Syringe	☐ **For patients weighing <100kg (220 lbs):** Inject 45mg SQ initially and 4 weeks later, followed by 45mg every 12 weeks ☐ **For patients weighing >100kg (220 lbs):** Inject 90mg SQ initially and 4 weeks later, followed by 90mg every 12 weeks		
☐ **Zelboraf**	☐ 240mg	☐ 4 tablets by mouth twice daily		

Prescription

Prescription:	Dose / Strength	Directions	Qty.	Refills:
☐ **Cimzia**	☐ 200mg/1ml Starter Kit ☐ 200mg/1ml Prefilled Syringe	**Initial Dose:** Inject 400mg SQ initially: repeat dose on weeks 2 and 4 **Maintenance:** Inject 400mg SQ every 4 weeks		
☐ **Dupixent**	☐ 300mg/2ml Prefilled Syringe	**Initial Dose:** Inject 600mg SQ divided in 2 different injection sites on day 1 **Maintenance:** Inject 300mg SQ every other week , startng day 15		
☐ **Taltz**	☐ 80mg/1ml Autoinjector ☐ 80mg/1ml Prefilled Syringe	**Initial Dose:** Inject 160mg SQ at week 0, followed by 80mg subQ at weeks 2, 4, 6, 8, 10 and 12 **Maintenance:** Inject 80mg SQ every 4 weeks		

Prescriber information

Prior Authorization:

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ FAX: _____

CONTACT PERSON: _____

I authorize Premier Pharmacy and it's representatives to act as an agent to initiate & execute prior authorization for above patient in order to expedite the process, please provide chart notes & most recent labs.

Physician's Signature: _____ ☐ DAW (Dispense as Written) Date ____ /____/____