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: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS.

Prescription

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)**
☐ **L50.1 Idiopathic Urticaria (Xolair)**
☐ **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**	☐ 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 weekly	4-week supply 4-week supply 4-week supply	2 _____ _____
☐ **Erivedge**	☐ 150mg capsule	☐ 1 capsule by mouth once daily	4-week supply	_____
☐ **Humira**	☐ Psoriasis Starter Package 40mg/0.8ml Prefilled AutoPen ☐ 40mg/0.8ml Prefilled AutoPen ☐ 40mg/0.8ml Prefilled Syringe **Hidradenitis Suppurativa (HS)** ☐ HS Starter Package 40mg/0.8ml Prefilled AutoPen ☐ 40mg/0.8ml Prefilled AutoPen ☐ 40mg/0.8ml Prefilled Syringe	☐ **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 week ☐ **Initial Dose:** Inject 160 mg SQ (four 40mg on day 1 or two 40mg on day 1 & 2), then 80 mg SQ on day 15 ☐ **Maintenance:** Inject 40mg SQ every week	Loading dose 4-week supply Loading dose 4-week supply	none _____ none _____
☐ **Otezla**	☐ Titration Starter Pack ☐ 30mg Tablet	☐ **Titration:** Take as directed per package instructions ☐ **Maintenance:** 30mg tablet orally twice daily	1 starter pack 60 tablets	none _____
☐ **Remicade**	☐ 100mg Vial	☐ **Initial dose:** Infuse _____mg or_____mg/kg at week 0, 2, 6 ☐ **Maintenance:** Infuse_____mg every_____ weeks thereafter	Loading dose _____	_____
☐ **Simponi**	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SQ once per month	4-week supply	_____
☐ **Stelara**	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/ml Prefilled Syringe	☐ **For patients weighing </=100kg (220 lbs):** Inject 45mg SQ on day 0, then week 4, then every 12 weeks ☐ **For patients weighing >/=100kg (220 lbs):** Inject 90mg SQ on day 0, then week 4, then every 12 weeks	1 1	_____ _____
☐ **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	6 syringes 2 syringes	none _____

Prescription

Prescription:	Dose / Strength	Directions	Qty.	Refills:
☐ **Dupixent**	☐ 300mg/2ml Prefilled Syringe	☐ **Initial Dose:** Inject 600mg SQ divided in 2 different injection sites on day 1, then 300mg every other week starting day 15 ☐ **Maintenance:** Inject 300mg SQ every other week	4 syringes 2 syringes	none _____
☐ **Taltz**	☐ 80mg/1ml Autoinjector ☐ 80mg/1ml Prefilled Syringe	☐ **Initial Dose:** Inject 160mg SQ at week 0, then 80mg week 2, then Inject 80mg at weeks 4, 6, 8 and 10, then Inject 80mg at week 12 ☐ **Maintenance:** Inject 80mg SQ every 4 weeks	3 2 1 1	none 1 none _____
☐ **Cosentyx**	☐ 150mg/ml Prefilled Syringe ☐ 150mg/ml Sensoready Pen ☐ 150mg/ml (2-Pen Pack) Sensoready Pen	☐ **Initial Dose:** Inject ☐ 300mg or ☐ 150mg SQ weekly at week 0, 1, 2, 3 and 4 ☐ **Maintenance:** Inject ☐ 300mg or ☐ 150mg SQ every 4 weeks	5-week supply 4-week supply	none _____
☐ **Tremfya**	☐ 100mg/ml Single-Dose Prefilled Syringe	☐ **Initial Dose:** Inject 100mg SQ at week 0, and on week 4 ☐ **Maintenance Dose:** Inject 100mg SQ every 8 weeks	1 1	1 _____
☐ **Xeljanz** ☐ **Xeljanz XR**	☐ 5mg tablet ☐ 11mg tablet	☐ Take 1 tablet orally twice daily ☐ Take 1 tablet orally once daily	60 tablets 30 tablets	_____ _____
☐ **Xolair**	☐ 150mg Powder for Solution Vial	☐ Inject 150mg SQ every 4 weeks ☐ Inject 300mg SQ every 4 weeks	1 vial 2 vials	_____ _____
☐ **Zelboraf**	☐ 240mg tablet	Take 4 tablets by mouth twice daily	240 tabs	_____
☐ **Botox Cosmetic**	☐ 50 Units Vial ☐ 100 Units Vial	**Dose:** _____ **Dose:** _____	_____ _____	_____ _____
☐ **Other**	_____ _____ _____	_____ _____ _____	_____	_____

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** ____ /____/____