PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

DERMATOLOGY 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: _____

SSN: _____ Alternate Contact Info: _____

Allergies: _____

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

Prescription

Gender: ☐ Male ☐ Female
Height: _____
Weight: _____
BSA: _____

Diagnosis:
☐ L20.9 Atopic Dermatitis
☐ L40.9 Psoriasis
☐ L40.52 Psoriatic Arthritis
☐ C44.91 Basal Cell Carcinoma (Erivedge)
☐ L50.1 Idiopathic Urticaria (Xolair)
☐ Other Diagnosis: ICD-10 Code
Description: _____
Date of Diagnosis: _____

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

Medication	Dose/Strength	Directions	Qty	Refills
☐ Skyrizi	☐ 150mg/ml Prefilled syringe ☐ 150mg/ml Prefilled pen	☐ **Initial Dose:** Inject 150mg SQ at week 0 and week 4 ☐ **Maintenance:** Inject 150mg SQ every 12 weeks	QS QS	1 _____
☐ Humira	**For Psoriasis** ☐ Citrate Free Psoriasis Starter Pack (80mg/0.8ml x1pen, 40mg/0.4ml x2pens) ☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	**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 week	Loading Dose 4 week supply	None _____
	For Hidradenitis Suppurativa (HS) ☐ Citrate Free HS Starter Pack (80mg/0.8ml x3pens) ☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	**For Hidradenitis Suppurativa (HS)** ☐ **Initial Dose:** Inject 160mg SQ (given in 1 day or over 2 consecutive days) then 80mg SQ on day 15 ☐ **Maintenance:** Inject 40mg SQ every week starting day 29 ☐ **Alternate Dose: Citrate Free 80mg/0.8ml Pen** Inject 80mg SQ every other week	Loading Dose 4 week supply 4 week supply	None _____ _____
☐ Enbrel	☐ 50mg/ml prefilled syringe ☐ 50mg/ml SureClick Autoinjector ☐ 50mg/ml Enbrel Mini-Cartridge	**For Psoriasis** ☐ **Initial Dose:** Inject 50mg SQ twice a week 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 _____ _____
☐ Cosentyx	☐ 150mg/ml Prefilled syringe ☐ 150mg/ml Sensoready Pen ☐ 150mg/ml (2-Pen Pack) Sensoready Pen ☐ 150mg/ml (2 Pack) PFS	☐ **Initial Dose:** Inject ☐ 150mg ☐ 300mg SQ weekly at week 0, 1, 2, 3, and 4 ☐ **Maintenance:** Inject ☐ 150mg ☐ 300mg SQ every 4 weeks	5wk supply 4wk supply	None _____
☐ 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 SYR 2 SYR	None _____
☐ Simponi	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SQ once per month	4 week supply	_____
☐ Dupixent ***(18+ years old)***	☐ 300mg/2ml Prefilled Syringe ☐ 300mg/2ml Prefilled Pen	☐ **Initial Dose:** Inject 600mg SQ divided in 2 different injection sites on day 1 ☐ **Maintenance:** Inject 300mg SQ every other week starting day 15	2 2	None _____

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Medication	Dose/Strength	Directions	Qty	Refills
☐ Dupixent ***(6-17 years old)***	☐ 200mg/1.14ml Prefilled Syringe ☐ 200 mg/1.14 ml Prefilled Pen ☐ 300mg/2ml Prefilled Syringe ☐ 300mg/2ml Prefilled Pen *(12+ years old)*	**For patients weighing 15 to less than 30kg:** ☐ **Initial Dose:** Inject 600mg SQ divided in 2 different injection sites on day 1 ☐ **Maintenance:** Inject 300mg SQ every 4 weeks starting day 29	2 2 (8 wks supply)	None ____
		For patients weighing 30 to less than 60kg: ☐ **Initial Dose:** Inject 400mg SQ divided in 2 different injection sites on day 1 ☐ **Maintenance:** Inject 200mg SQ every 2 weeks starting day 15	2 2	None ____
		For patients weighing 60kg or more: ☐ **Initial Dose:** Inject 600mg SQ divided in 2 different injection sites on day 1 ☐ **Maintenance:** Inject 300mg SQ every 2 weeks starting day 15	2 2	None ____
☐ Erivedge	☐ 150mg capsule	☐ 1 capsule by mouth once daily	4 week supply	_____
☐ Ilumya	☐ 100mg/ml Prefilled Syringe	☐ Inject 100mg SQ at weeks 0, 4, and then every 12 weeks thereafter	1 SYR	_____
☐ Otezla	☐ Titration Starter Pack ☐ 30mg tablet	☐ **Titration:** Take as directed per package instructions ☐ **Maintenance:** 30mg tablet orally twice a day every morning and evening	1 starter pack 60 tabs	None _____
☐ Siliq	☐ 210mg/1.5ml Prefilled Syringe	☐ **Initial Dose:** Inject 210mg SQ at weeks 0, 1, and 2 ☐ **Maintenance:** Inject 210mg SQ every 2 weeks (starting week 4)	3 SYR 2 SYR	None _____
☐ Stelara	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/ml Prefilled Syringe	**For patients weighing ≤ 100kg (220lbs):** ☐ **Initial Dose:** Inject 45mg SQ on day 0 then week 4 ☐ **Maintenance:** Inject 45mg SQ every 12 weeks **For patients weighing ≥ 100kg (220lbs):** ☐ **Initial Dose:** Inject 90mg SQ on day 0 then week 4 ☐ **Maintenance:** Inject 90mg SQ every 12 weeks	1 SYR 1 SYR 1 SYR 1 SYR	1 _____ 1 _____
☐ Taltz	☐ 80mg/1ml Autoinjector ☐ 80mg/1ml Prefilled Syringe	**For Psoriasis (PsO)** ☐ **Initial Dose:** Inject 160mg SQ at week 0, then 80mg at week 2 Then inject 80mg at week 4, 6, 8, and 10 Then inject 80mg at week 12 **For Psoriatic Arthritis (PsA)** ☐ **Initial Dose:** Inject 160mg SQ at week 0 **For PsO and PsA** ☐ **Maintenance:** Inject 80mg SQ every 4 weeks after initial dose	3 2 1 2 1	None 1 None None _____
☐ Tremfya	☐ 100mg/ml Single-Dose PFS ☐ 100mg/ml Autoinjector	☐ **Initial Dose:** Inject 100mg SQ at week 0 and on week 4 ☐ **Maintenance:** Inject 100mg SQ every 8 weeks	1 1	1 _____
☐ Xeljanz ☐ Xeljanz XR	☐ 5mg tablet ☐ 11mg tablet	☐ Take 1 tablet orally twice a day every morning and evening ☐ Take 1 tablet orally once a day	60 tabs 30 tabs	_____
☐ Other	_____	_____	_____	_____

Prescriber Information

PRIOR AUTHORIZATION

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

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

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

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____