

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

Patient Information	Patient Last Name: _____ DOB: _____ SSN: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Alt Phone: _____
	Alternate Contact Info: _____
	Allergies: _____

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

Clinical Information	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Diagnosis:	Has TB test been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Height: _____	<input type="checkbox"/> L20.9 Atopic Dermatitis	Does patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Weight: _____	<input type="checkbox"/> L40.9 Psoriasis	
	BSA: _____	<input type="checkbox"/> L40.52 Psoriatic Arthritis	
		<input type="checkbox"/> C44.91 Basal Cell Carcinoma (Erivedge)	
		<input type="checkbox"/> L50.1 Idiopathic Urticaria (Xolair)	
	<input type="checkbox"/> Other Diagnosis: ICD-10 Code _____		Start Date: _____
	Description: _____		Review Date: _____
	Date of Diagnosis: _____		

	Medication	Dose/Strength	Directions	Qty	Refills
Prescription Information	<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150mg/ml Prefilled syringe <input type="checkbox"/> 150mg/ml Prefilled pen	<input type="checkbox"/> Initial Dose: Inject 150mg SQ at week 0 and week 4 <input type="checkbox"/> Maintenance: Inject 150mg SQ every 12 weeks	QS QS	1 _____
	<input type="checkbox"/> Humira	For Psoriasis <input type="checkbox"/> Citrate Free Psoriasis Starter Pack (80mg/0.8ml x1pen, 40mg/0.4ml x2pens) <input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	For Psoriasis <input type="checkbox"/> Initial Dose: Inject 80mg SQ once on day 1, then 40mg on day 8, then 40mg every other week <input type="checkbox"/> Maintenance: Inject 40mg SQ every other week	Loading Dose 4 week supply	None _____
		For Hidradenitis Suppurativa (HS) <input type="checkbox"/> Citrate Free HS Starter Pack (80mg/0.8ml x3pens) <input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	For Hidradenitis Suppurativa (HS) <input type="checkbox"/> Initial Dose: Inject 160mg SQ (given in 1 day or over 2 consecutive days) then 80mg SQ on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SQ every week starting day 29 <input type="checkbox"/> Alternate Dose: Citrate Free 80mg/0.8ml Pen Inject 80mg SQ every other week	Loading Dose 4 week supply 4 week supply	None _____ _____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg/ml prefilled syringe <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 50mg/ml Enbrel Mini-Cartridge	For Psoriasis <input type="checkbox"/> Initial Dose: Inject 50mg SQ twice a week for 3 months <input type="checkbox"/> Maintenance: Inject 50mg SQ weekly For Psoriatic Arthritis <input type="checkbox"/> Inject 50mg SQ weekly	4 week supply 4 week supply 4 week supply	2 _____ _____	

Referral Form Continued on Next Page

Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg/ml Prefilled syringe <input type="checkbox"/> 150mg/ml Sensoready Pen <input type="checkbox"/> 150mg/ml (2-Pen Pack) Sensoready Pen <input type="checkbox"/> 150mg/ml (2 Pack) PFS	<input type="checkbox"/> Initial Dose: Inject <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg SQ weekly at week 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg SQ every 4 weeks	5wk supply 4wk supply	None _____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/1ml Starter Kit <input type="checkbox"/> 200mg/1ml Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 400mg SQ initially: repeat dose on weeks 2 and 4 For Psoriatic Arthritis <input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks For Plaque Psoriasis <input type="checkbox"/> Maintenance: Inject 400mg SQ every other week <input type="checkbox"/> Alternate Maintenance Dosing for Patients Weighing Less Than 90kg: Inject 400mg SQ every 4 weeks	6 SYR 2 SYR 4 SYR 2 SYR	None _____ _____ _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SQ once per month	4 week supply	_____
<input type="checkbox"/> Dupixent (18+ years old)	<input type="checkbox"/> 300mg/2ml Prefilled Syringe <input type="checkbox"/> 300mg/2ml Prefilled Pen	<input type="checkbox"/> Initial Dose: Inject 600mg SQ divided in 2 different injection sites on day 1 <input type="checkbox"/> Maintenance: Inject 300mg SQ every other week starting day 15	2 2	None _____
<input type="checkbox"/> Dupixent (6-17 years old)	<input type="checkbox"/> 200mg/1.14ml Prefilled Syringe <input type="checkbox"/> 200 mg/1.14 ml Prefilled Pen <input type="checkbox"/> 300mg/2ml Prefilled Syringe <input type="checkbox"/> 300mg/2ml Prefilled Pen (12+ years old)	For patients weighing 15 to less than 30kg: <input type="checkbox"/> Initial Dose: Inject 600mg SQ divided in 2 different injection sites on day 1 <input type="checkbox"/> Maintenance: Inject 300mg SQ every 4 weeks starting day 29	2 2 (8 wks supply)	None _____
		For patients weighing 30 to less than 60kg: <input type="checkbox"/> Initial Dose: Inject 400mg SQ divided in 2 different injection sites on day 1 <input type="checkbox"/> Maintenance: Inject 200mg SQ every 2 weeks starting day 15	2 2	None _____
		For patients weighing 60kg or more: <input type="checkbox"/> Initial Dose: Inject 600mg SQ divided in 2 different injection sites on day 1 <input type="checkbox"/> Maintenance: Inject 300mg SQ every 2 weeks starting day 15	2 2	None _____
<input type="checkbox"/> Erivedge	<input type="checkbox"/> 150mg capsule	<input type="checkbox"/> Take 1 capsule by mouth once daily	4 week supply	_____
<input type="checkbox"/> Ilumya	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 100mg SQ at weeks 0, 4, and then every 12 weeks thereafter	1 SYR	_____
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack <input type="checkbox"/> 30mg tablet	<input type="checkbox"/> Titration: Take as directed per package instructions <input type="checkbox"/> Maintenance: 30mg tablet orally twice a day every morning and evening	1 starter pack 60 tabs	None _____
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg ER tablet <input type="checkbox"/> 30mg ER tablet	For Atopic Dermatitis For patients ≥ 12 years weighing at least 40kg and adults <65 years old: <input type="checkbox"/> Take 15mg ER tablet by mouth once daily <input type="checkbox"/> Take 30mg ER tablet by mouth once daily (if adequate response not achieved)	30 tabs 30 tabs	_____ _____
		For patients ≥ 65years old: <input type="checkbox"/> 15mg ER tablet by mouth once daily	30 tabs	_____
<input type="checkbox"/> Siliq	<input type="checkbox"/> 210mg/1.5ml Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 210mg SQ at weeks 0, 1, and 2 <input type="checkbox"/> Maintenance: Inject 210mg SQ every 2 weeks (starting week 4)	3 SYR 2 SYR	None _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 90mg/ml Prefilled Syringe	For patients weighing ≤ 100kg (220lbs): <input type="checkbox"/> Initial Dose: Inject 45mg SQ on day 0 then week 4 <input type="checkbox"/> Maintenance: Inject 45mg SQ every 12 weeks	1 SYR 1 SYR	1 _____
		For patients weighing ≥ 100kg (220lbs): <input type="checkbox"/> Initial Dose: Inject 90mg SQ on day 0 then week 4 <input type="checkbox"/> Maintenance: Inject 90mg SQ every 12 weeks	1 SYR 1 SYR	1 _____

Prescription Information

		Medication	Dose/Strength	Directions	Qty	Refills
Prescription Information	<input type="checkbox"/>	Taltz	<input type="checkbox"/> 80mg/1ml Autoinjector <input type="checkbox"/> 80mg/1ml Prefilled Syringe	For Psoriasis (PsO) <input type="checkbox"/> 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) <input type="checkbox"/> Initial Dose: Inject 160mg SQ at week 0 For PsO and PsA <input type="checkbox"/> Maintenance: Inject 80mg SQ every 4 weeks after initial dose	3 2 1 2 1	None 1 None None _____
	<input type="checkbox"/>	Tremfya	<input type="checkbox"/> 100mg/ml Single-Dose PFS <input type="checkbox"/> 100mg/ml Autoinjector	<input type="checkbox"/> Initial Dose: Inject 100mg SQ at week 0 and on week 4 <input type="checkbox"/> Maintenance: Inject 100mg SQ every 8 weeks	1 1	1 _____
	<input type="checkbox"/>	Xeljanz	<input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Take 1 tablet orally twice a day every morning and evening	60 tabs	_____
	<input type="checkbox"/>	Xeljanz XR	<input type="checkbox"/> 11mg tablet	<input type="checkbox"/> Take 1 tablet orally once a day	30 tabs	_____
	<input type="checkbox"/>	Other	_____	_____	_____	_____

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: ____/____/____

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