# Dermatology Order Form

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## Patient Information

Patient name ______________________________

Address ______________________________

City ____________________ State ________ Zip _________

Home phone ______________________ Cell ______________________

DOB __________________ SSN ______________________________

Drug allergies ______________________________ ❍Male ❍Female

## Prescriber Information

Prescriber name ______________________________ Lic# ______________

DEA# ______________________ Tax ID ______________________

Practice name ______________________________

Address ______________________________ Suite ____________

City ______________________________ State ________ Zip __________

Office Phone ______________________ Fax ______________________

## Insurance, Medicare or Medicaid Information

Primary Insurance ______________________________

Policy # ______________________ Group ______________________

Insurance phone ______________________________

Secondary Insurance( *If applicable*.) ______________________________

Policy # ______________________ Group ______________________

Insurance phone ______________________________

Prescription Drug Coverage: Company ______________________________ Phone ______________________________

RXGRP# ______________________ RXBIN# ______________________ PCN/ID# (if avail.) ______________________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE , PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

## Clinical Information

Diagnosis: ❍696.1 Psoriasis ❍ 696.0 Psoriatic Arthritis ❍Other ______________ Loc. of psoriasis: ❍Hands ❍Feet ❍Scalp ❍Groin ❍Nails ❍Other: __________

Severity of psoriasis: ❍Mild (up to 3% BSA) ❍Moderate (3-10% BSA) ❍Severe ( >10% BSA), BSA __________% Previously treated for this condition? ❍Yes ❍No

Medication/Therapy failed & length: ❍Topical ______ ❍Light therapy ______ ❍Methotrexate ______ ❍Soriatane ______ ❍Cyclosporine ______ ❍Others ____________

Is patient currently on therapy? ❍Yes ❍ No Type/medication(s): ______________________________ Patient tested for TB/PPD? ❍ Yes ❍No Results ________

Will patient stop the above medication(s) before starting the new medication? ❍Yes ❍No If yes, how long should patient wait before starting new medication? ______________

Other medications patient is currently taking including OTC medications w/ dosage & directions (or fax medication profile): ______________________________

| Drug name | Prescription Orders (PLEASE CHECK ONE OR MORE) | Quantity | Refills |
|---|---|---|---|
| Enbrel ® 50mg/ml<br>❍SureClick Auto-Injector<br>❍PFS (prefilled syringes) | ❍**Induction:** inject 50mg SC twice weekly for three months then maintenance dose<br>❍**Maintenance:** 50mg SC weekly<br>❍**Other:** ______________________________ | 28 day supply | Refills |
| Enbrel® 25mg/0.5ml<br>❍Pre-filled syringe<br>❍Vial kit | ❍25mg SC twice weekly<br>❍**Other:** ______________________________ | 28 day supply | Refills |
| Humira®<br>❍Pen<br>❍Syringe | ❍**Induction:** Inject 80mg (2 pens) SC on Day 1, then 40 mg (1 Pen) on Day 8, followed by maintenance dose<br>❍**Maintenance**: 40mg SC every other week [OR] ❍ **Other:** ______________________ | 28 day supply | Refills |
| ❍Stelara® 45mg/0.5ml | ❍**≤ 100kg Body Weight:** Inject 45mg SC on Day 1, again after 4 weeks, then every 12 weeks thereafter.<br>❍**> 100kg Body Weight:** Inject 90mg SQ on Day 1, again after 4 weeks, then every 12 weeks thereafter<br>Either dose is to be administered by a healthcare provider. | 28 Day supply initially, to be refilled after 4 weeks, then every 12 weeks thereafter. | Approved for how many months? ________ |
| ❍Remicade®<br>100mg vial | Directions | Qty | Refills |
| Other Medications: | Directions | Qty | Refills |
| Other Medications: | Directions | Qty | Refills |

**Deliver to:** ❍ Patient's home ❍MD's office ❍ 1st dose to MD's office, remaining refills to patient home **Injection training needed?** ❍Yes ❍ No

*We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.*

______________________________ ______________________ ______________________

**Prescriber signature and/or Name of Authorized Agent (RN, CNP, MA, etc.)** **Preferred phone number & extension** **Date**