Dermatology (I-Z)

(Otezla®, Siliq™, Simponi®, Stelara®, Taltz®)

Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.826.2596

Patient Information

Patient name: __________________________ DOB: ______________

Sex: ❑ Female ❑ Male SSN: _________________________________

Language: _____________ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in

Address: ____

Apt/Suite: _____ City: _________________ State: _____ Zip: ______

Phone: ____________________ Alternate: _____________________

Caregiver name: _____________________ Relation: ______________

Local pharmacy: ______________________ Phone: ______________

Insurance plan: __________________ Plan ID: _________________

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ____

NPI: ____

Address: ____

Apt/Suite: ______ City: ____________ State: _______ Zip: ______

Contact: ____

Phone: ______________________ Alternate: _________________

Fax: ____

Email: ____

If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) ❑ L40.8 (Other psoriasis) ❑ L40.9 (Psoriasis, unspecified) ❑ L40.5____ (Psoriatic arthritis) ❑ L73.2 (Hidradenitis Suppurativa) ❑ ______________

Diagnosis Date: ________ TB test: ❑ Yes ❑ No Neg. Test Date: _________ HBV: ❑ Yes ❑ No If yes, currently treated: ❑ Yes ❑ No

BSA affected (%): _________ Affected areas: ❑ Palms ❑ Soles ❑ Head ❑ Neck ❑ Genitalia ❑ ____________________

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
____________________	______________________________	______________	______________
____________________	______________________________	______________	______________
____________________	______________________________	______________	______________

Comorbidities: ____

Concomitant Medications: ____

Allergies: ❑ NKDA ❑ Other: ____

Prescription

§ Cimzia®, Cosentyx®, Dupixent®, Enbrel®, Humira® are available on the Dermatology Enrollment Form A-H §

Prescription		Quantity		Refill
❑ **Otezla® (apremilast)**	❑ Take as directed per package instructions	❑ 55 tablets	28-day starter pack	0
	❑ Take 30 mg twice daily by mouth ❑ ________________________________	❑ 60 x 30 mg tablets ❑ ______________		_____
Siliq™ (brodalumab)	❑ Inject 210 mg subcut on weeks 0, 1, and 2 followed by 210 mg subcut every 2 weeks thereafter	❑ 3 x 210 mg/1.5 mL	PFS	0
	❑ Inject 210 mg subcut every 2 weeks	❑ 2 x 210 mg/1.5 mL	PFS	_____
❑ **Simponi® (golimumab)** Psoriatic Arthritis	❑ Inject 50 mg subcut once a month	❑ 1 x 50 mg/0.5mL	❑ SmartJect® Autoinjector ❑ PFS	_____
❑ **Stelara® (ustekinumab)**	❑ Inject 45 mg subcut on Day 1 (≤100 kg) ❑ Inject 90 mg subcut on Day 1 (>100 kg)	❑ 1 x 45 mg/0.5mL ❑ 1 x 90 mg/mL	PFS	0
	❑ Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤100 kg) ❑ Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (>100 kg)	❑ 1 x 45 mg/0.5mL ❑ 1 x 90 mg/mL	PFS	_____
	Patient eligible for self-administration: ❑ Yes ❑ No			
❑ **Taltz® (Ixekizumab)**	Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subcut at week 0, then inject 80 mg subcut at week 2	❑ 3 x 80 mg/mL	Autoinjectors PFS	0
	❑ Weeks 4 - 10: Inject 80 mg subcut at week 4 and every **two** weeks thereafter through week 10	❑ 2 x 80 mg/mL	Autoinjectors PFS	1
	❑ Week 12 onwards: Inject 80 mg subcut at week 12 and every **four** weeks thereafter	❑ 1 x 80 mg/mL	Autoinjectors PFS	_____

Injection Training Provided by: ❑ Physician's Office ❑ Pharmacy ❑Other: ______________________________

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ____________________

Prescriber's Signature:____ Date: ________________

I authorize Thrifty White Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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