ahma (rx)

DERMATOLOGY

Toll free phone: 844.749.6628
Toll free fax: 888.966.0647

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:			

Prescriber Information

Practice Name:		Office Contact:	
Prescriber :		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Diagnosis/ICD-10: ____	Prior Failed Medications : ☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ PUVA ☐ Simponi® ☐ Stelara® ☐ Other:_____ ☐ Topical (please list): _____		Does the patient have a latex allergy? ☐ Yes ☐ No
TB/PPD test given? ☐ Yes ☐ No *** Please provide documentation***	Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐ Yes ☐ No	% BSA affected: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia	IGA Score: _____

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Cimzia® (psoriatic arthritis)	☐ 200 mg prefilled syringe	☐ Starter dose: inject 400 mg Sub -Q at weeks 0, 2, and 4	1 Starter pack	
		☐ Maintenance dose: inject 400 mg Sub -Q every 4 weeks ☐ Maintenance dose: inject 200 mg Sub -Q every 2 weeks	2 syringes	
☐ Cosentyx®	☐ 150 mg/mL Sensoready® pen ☐ 150 mg/mL prefilled syringe	With a loading dose: ☐ Inject 150 mg Sub -Q on week 0, 1, 2, 3 and 4 then inject 150 mg Sub -Q once every 4 weeks **(FOR PSORIATIC ARTHRITIS)** Without a loading dose: ☐ Inject 150 mg Sub -Q once every 4 weeks **(FOR PSORIATIC ARTHRITIS)**	1 pen/syringe	
		☐ Inject 300 mg Sub -Q on week 0, 1, 2, 3 and 4 then inject 300 mg Sub -Q once every 4 weeks ☐ Inject 300 mg Sub -Q every 4 weeks **(FOR PLAQUE PSORIASIS)**	3 pens/syringes	
☐ Dupixent®	☐ 300 mg/2 mL solution in a single -dose pre-filled syringe with needle shield	☐ Starter dose: inject 600 mg (2 syringes in 2 different injection sites) Sub -Q day 1 ☐ Maintenance dose: inject 300 mg Sub -Q every other week (starting 14 days after day 1)	2 syringes	
☐ Enbrel®	☐ 50 mg/mL prefilled syringe ☐ 50 mg/mL SureClick™ autoinjector	☐ Starter dose: inject 50 mg Sub - Q twice a week (72 - 96 hours apart for 3 months)	8 pens/syringes	
		☐ Maintenance dose: inject 50 mg Sub -Q once a week	4 pens/syringes	
☐ Humira®	☐ 40 mg/0.8 mL pen ☐ 40 mg/0.8 mL prefilled syringe	☐ Starter dose: inject 80 mg Sub- Q day 1 ☐ Maintenance dose: inject 40 mg Sub - Q every other week (starting 1 week after initial dose)	☐ Starter pack ☐ 2 pens/syringes	
		For Hidradenitis Suppurativa only: ☐ Starter dose: inject 160 mg Sub-Q day 1 , then 80 mg 14 days after, then 40 mg on day 29 ☐ Maintenance dose: inject 40 mg Sub -Q every week (st arting 1 week after day 29 dose)	☐ Starter pack ☐ 4 pens/syringes	
☐ Ilumya ™	☐ 100 mg/mL prefilled syringe	☐ Starter Dose: inject 100 mg Sub-Q at week 0 and week 4 ☐ Maintenance dose: inject 100 mg Sub -Q every 12 weeks	1 prefilled syringe	
☐ Otezla®	☐ Starter Pack	Titrate dose days 1 through 5 and as directed thereafter	1 pack	
	☐ Bridge Pack	☐ Take 30 mg by mouth once daily ☐ Take 30 mg by mouth twice dai ly	28 tabs	
	☐ 30 mg tablet	Take 30 mg by mouth twice daily ***(Titration Date: ____/____/_____)***	60 tabs	
☐ Remicade®	☐ 100 mg vial	Infuse IV at 5 mg/kg (Dose = _____mg) at week 0, week 2, week 6 and every 8 weeks thereafter. (For Plaque psoriasis and Psoriatic arthritis)	Quantity: ___ # of 100 mg vials	
☐ Simponi® (psoriatic arthritis)	☐ 50 mg/0.5 mL SmartJect® autoinjector ☐ 50 mg/0.5 mL prefilled syringe	Inject 50 mg Sub -Q once a month	1 pen/syringe	
☐ Stelara®	☐ 45 mg/0.5 mL prefilled syringe (<100 kg) ☐ 90 mg/1 mL prefilled syringe (>100 k g)	☐ Inject contents of 1 syringe Sub -Q on day 0, 4 weeks later, and then every 12 weeks ☐ Inject 1 syringe Sub -Q every 12 weeks	1 syringe	
☐ Taltz®	☐ 80 mg/ml autoinjector ☐ 80 mg/ml prefilled syringe	☐ Starter dose: inject 160 mg Sub -Q at week 0 , then begin induction dose 2 weeks later	3 pens/syringes	
		☐ Induction dose: inject 80 mg Sub -Q every two weeks (weeks 4 – 10)	2 pens/syringes	
		☐ Final Induction dose: inject 80 mg Sub -Q at week 12	1 pen/syringe	
		☐ Maintenance dose: inject 80 mg Sub -Q every 4 weeks (thereafter)	1 pen/syringe	
☐ Tremfya™	100 mg/ml prefilled syringe	☐ Starter dose: inject 100 mg Sub -Q at weeks 0, 4 and then every 8 weeks after ☐ Maintenance dose: inject 100mg Sub -Q every 8 weeks	1 syringe	
☐ Siliq™	210 mg/1.5 mL prefilled syringe	☐ Starter dose: inject 210 mg Sub -Q at weeks 0, 1 and 2 and then then every 2 weeks after ☐ Maintenance dose: inject 210mg Sub -Q every 2 weeks	2 pens	
☐ Xeljanz®	5 mg tablets	Take 1 tablet by mouth twice daily for psoriatic arthritis	60 tabs	
☐ Xeljanz® XR	11 mg tablets	Take 1 tablet by mouth daily with or without food for psoriatic arthritis	30 tabs	
☐ Other:				

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____ Date _____

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