Dermatology (drugs A-H)

(Cimzia®, Cosentyx®, Dupixent®, Enbrel®, Humira®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

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: ☐ L20.____ (Atopic Dermatitis) ☐ 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		Quantity		Refill
☐ **Cimzia®** **(certolizumab)** *Psoriatic Arthritis*	☐ Inject 400 mg subcut at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 200 mg subcut every 2 weeks ☐ Inject 400 mg subcut every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	_____
☐ **Cosentyx®** **(secukinumab)**	☐ Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 ☐ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150 mg/mL ☐ 8 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	0
	☐ Inject 150 mg subcut on week 4 and every 4 weeks thereafter ☐ Inject 300 mg subcut on week 4 and every 4 weeks thereafter	☐ 1 x 150 mg/mL ☐ 2 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	_____
☐ **Dupixent®** **(dupilumab)**	☐ Inject 600 mg subcut on day 1, followed by 300 mg subcut at day 15, and every 2 weeks thereafter	☐ 4 x 300 mg/2mL	☐ PFS	0
	☐ Inject 300 mg subcut every 2 weeks	☐ 2 x 300 mg/2mL	☐ PFS	_____
☐ **Enbrel®** **(etanercept)** *Adult*	☐ Inject 50 mg subcut twice a week (72-96 hours apart) for 3 months	☐ 8 x 50 mg/mL	☐ SureClick® Autoinjector ☐ PFS	2
	☐ Inject 50 mg subcut every week	☐ 4 x 50 mg/mL	☐ SureClick® Autoinjector ☐ PFS	_____
☐ **Enbrel®** **(etanercept)** *Pediatric (4-17 yrs)*	☐ Inject _____ mg (0.8mg/kg x _____kg subcut every week (≤ 63 kg)	☐___ x 25 mg/mL	☐ Vials ☐ PFS	_____
	☐ Inject 50 mg subcut every week (> 63 kg)	☐ 4 x 50 mg/mL	☐ SureClick® Autoinjector ☐ PFS	_____
☐ **Humira®** **(adalimumab)**	☐ **Plaque Psoriasis:** Inject 80 mg subcut day 1, then 40 mg on day 8, then 40 mg every 2 weeks thereafter ☐ **Hidradenitis Suppurativa:** Inject 160 mg subcut on day 1, then 80 mg on day 15 ☐ _____	☐ 4 x 40 mg/0.8mL ☐ 6 x 40 mg/0.8mL	☐ Pens ☐ PFS	0
	☐ **Plaque Psoriasis:** Inject 40 mg subcut every 2 weeks ☐ **Hidradenitis Suppurativa:** Inject 40 mg subcut on day 29 and every week thereafter	☐ 2 x 40 mg/0.8mL ☐ 4 x 40 mg/0.8mL	☐ Pens ☐ PFS	_____

§ Otezla®, Siliq™, Simponi®, Stelara®, Taltz® are available on the Dermatology Enrollment Form I-Z §

Injection Training Provided by: ☐ Physician's Office ☐ Pharmacy ☐ Other: _____

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

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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