

# Dermatology (drugs A-H)



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

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

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

## 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: \_\_\_\_\_  
 Concomitant Medications: \_\_\_\_\_  
 Allergies:  NKDA  Other: \_\_\_\_\_

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

**§ Orencia®, 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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