

Dermatology (drugs I-S)

(Orencia®, Otezla®, Simponi®, Stelara®)



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: 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: _____

Patient eligible for self-administration: Yes No

Prescription

Prescription	Quantity	Refill
§ Cimzia®, Cosentyx®, Dupixent®, Enbrel®, Humira® are available on the Dermatology Enrollment Form A-H §		
Orencia® (abatacept) <i>Psoriatic Arthritis</i>	Infuse _____ mg at week 0 and 2	_____ x 250 mg/mL Vials
	Infuse _____ mg at week 4 and every 4 weeks thereafter	_____ x 250 mg/mL Vials
	< 60 kg = 500 mg, 60 to 100 kg = 750 mg, > 100 kg = 1000 mg	
	Inject 125 mg subcut once weekly	4 x 125 mg/mL PFS ClickJect™ Autoinjector
Otezla® (apremilast)	<input type="checkbox"/> Take as directed per package instructions	<input type="checkbox"/> 55 tablets 28-day starter pack
	<input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 60 x 30 mg tablets
	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Simponi® (golimumab) <i>Psoriatic Arthritis</i>	<input type="checkbox"/> Inject 50 mg subcut once a month	<input type="checkbox"/> 1 x 50 mg/0.5mL SmartJect® Autoinjector PFS
Stelara® (ustekinumab)	<input type="checkbox"/> Inject 45 mg subcut on Day 1 (≤100 kg)	<input type="checkbox"/> 1 x 45 mg/0.5mL PFS
	<input type="checkbox"/> Inject 90 mg subcut on Day 1 (>100 kg)	<input type="checkbox"/> 1 x 90 mg/mL PFS
	<input type="checkbox"/> Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤100 kg)	<input type="checkbox"/> 1 x 45 mg/0.5mL PFS
	<input type="checkbox"/> Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (>100 kg)	<input type="checkbox"/> 1 x 90 mg/mL PFS

§ Taltz® and Tremfya™ are available on the Dermatology Enrollment Form T-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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 810.768.9178 or by emailing compliance@diplomat.is to obtain instructions as to the proper destruction of the transmitted material. Thank you.