

# Dermatology (drugs I-Z)



(Otezla<sup>®</sup>, Siliq<sup>™</sup>, Simponi<sup>®</sup>, Stelara<sup>®</sup>, Taltz<sup>®</sup>)

| 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)   |   |  |  |
|--|---|--|--|
| <b>Diagnosis:</b> <input type="checkbox"/> L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) <input type="checkbox"/> L40.8 (Other psoriasis)<br><input type="checkbox"/> L40.9 (Psoriasis, unspecified) <input type="checkbox"/> L40.5 (Psoriatic arthritis) <input type="checkbox"/> L73.2 (Hidradenitis Suppurativa) <input type="checkbox"/> _____  |   |  |  |
| Diagnosis Date: _____ TB test: <input type="checkbox"/> Yes <input type="checkbox"/> No Neg. Test Date: _____ HBV: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, currently treated: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>BSA affected (%): _____ Affected areas: <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia <input type="checkbox"/> _____ |   |  |  |
| Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No<br>_____<br>_____   | Reason for Discontinuation of Therapy<br>_____<br>_____ | Approximate Start Date<br>_____<br>_____ | Approximate End Date<br>_____<br>_____ |
| Comorbidities: _____   |   |  |  |
| Concomitant Medications: _____   |   |  |  |
| Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____   |   |  |  |

| Prescription   | Quantity  | Refill   |
|--|---|--|
| § Cimzia <sup>®</sup> , Cosentyx <sup>®</sup> , Dupixent <sup>®</sup> , Enbrel <sup>®</sup> , Humira <sup>®</sup> are available on the Dermatology Enrollment Form A-H § |   |  |
| <input type="checkbox"/> Otezla <sup>®</sup><br>(apremilast)   | <input type="checkbox"/> Take as directed per package instructions<br><input type="checkbox"/> Take 30 mg by mouth twice daily<br><input type="checkbox"/> _____  | <input type="checkbox"/> 55 tablets<br><input type="checkbox"/> 60 x 30 mg tablets<br><input type="checkbox"/> _____<br>28-day starter pack<br>0   |
| <input type="checkbox"/> Siliq <sup>™</sup><br>(brodalumab)  | <input type="checkbox"/> Inject 210 mg subcut on weeks 0, 1, and 2 followed by 210 mg subcut every 2 weeks thereafter<br><input type="checkbox"/> Inject 210 mg subcut every 2 weeks  | <input type="checkbox"/> 3 x 210 mg/1.5 mL<br><input type="checkbox"/> 2 x 210 mg/1.5 mL<br>PFS<br>PFS<br>0<br>_____   |
| <input type="checkbox"/> Simponi <sup>®</sup><br>(golimumab)<br>Psoriatic Arthritis  | <input type="checkbox"/> Inject 50 mg subcut once a month   | <input type="checkbox"/> 1 x 50 mg/0.5mL<br><input type="checkbox"/> SmartJect <sup>®</sup> Autoinjector<br><input type="checkbox"/> PFS<br>_____  |
| <input type="checkbox"/> Stelara <sup>®</sup><br>(ustekinumab)   | <input type="checkbox"/> Inject 45 mg subcut on Day 1 (≤100 kg)<br><input type="checkbox"/> Inject 90 mg subcut on Day 1 (>100 kg)<br><input type="checkbox"/> Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤100 kg)<br><input type="checkbox"/> Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (>100 kg)                                | <input type="checkbox"/> 1 x 45 mg/0.5mL<br><input type="checkbox"/> 1 x 90 mg/mL<br><input type="checkbox"/> 1 x 45 mg/0.5mL<br><input type="checkbox"/> 1 x 90 mg/mL<br>PFS<br>PFS<br>0<br>_____                 |
| Patient eligible for self-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| <input type="checkbox"/> Taltz <sup>®</sup><br>(ixekizumab)  | <input type="checkbox"/> Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subcut at week 0, then inject 80 mg subcut at week 2<br><input type="checkbox"/> Weeks 4 - 10: Inject 80 mg subcut at week 4 and every <b>two</b> weeks thereafter through week 10<br><input type="checkbox"/> Week 12 onwards: Inject 80 mg subcut at week 12 and every <b>four</b> weeks thereafter | <input type="checkbox"/> 3 x 80 mg/mL<br><input type="checkbox"/> 2 x 80 mg/mL<br><input type="checkbox"/> 1 x 80 mg/mL<br>Autoinjectors<br>PFS<br>Autoinjectors<br>PFS<br>Autoinjectors<br>PFS<br>0<br>1<br>_____ |

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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