Dermatology (drugs F-R)

DIPLOMAT®

(Humira®, Orencia®, Otezla®)

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: ❑ 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: ___________________________________

Has the patient received their starter dose(s)/kit? Yes; Start Date __________ No

Prescription

§ Cimzia®, Cosentyx®, Dupixent®, and Enbrel® are listed alphabetically on respective enrollment forms.§

Prescription		Quantity		Refill
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/0.8 mL 6 x 40 mg/0.8 mL	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/0.8 mL 4 x 40 mg/0.8 mL	Pens PFS	_____
Orencia® (abatacept)	Infuse _____ mg at week 0 and 2	_____ x 250 mg/mL	Vials	0
	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			
Psoriatic Arthritis	Inject 125 mg subcut once weekly	4 x 125 mg/mL	PFS ClickJect™ Autoinjector	_____
Otezla® (apremilast)	❑ Take as directed per package instructions	❑ 55 tablets	28-day starter pack	0
	❑ Take 30 mg by mouth twice daily ❑ ______________________	❑ 60 x 30 mg ❑ ____________	Tablets	_____

§Siliq™, Simponi®, Simponi Aria®, Stelara®, Taltz® and Tremfya™ are listed alphabetically on respective enrollment forms.§

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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