

(Humira®, Orenzia®, Otezla®)

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: <input type="checkbox"/> L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) <input type="checkbox"/> L40.8 (Other psoriasis) <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 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 _____ _____	Reason for Discontinuation of Therapy _____ _____	Approximate Start Date _____ _____	Approximate End Date _____ _____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

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

Prescription	Quantity	Refill	
§ Cimzia®, Cosentyx®, Dupixent®, and Enbrel® are listed alphabetically on respective enrollment forms. §			
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 _____
Orenzia® (abatacept) <i>Psoriatic Arthritis</i>	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 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 0
	<input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 60 x 30 mg	Tablets _____
	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____

§ 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.

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.