

| 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: \_\_\_\_\_

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

| Prescription | Quantity | Refill |
|--------------|----------|--------|
|--------------|----------|--------|

**§ Cimzia®, Cosentyx®, Dupixent®, Enbrel®, Humira®, Orencia®, Otezla®, Siliq™, Simponi®, Simponi Aria®, and Stelara® are listed alphabetically on respective enrollment forms. §**

|                                  |   |               |                      |       |
|----------------------------------|---|---------------|----------------------|-------|
| <b>Taltz®<br/>(Ixekizumab)</b>   | Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subcut at week 0, then inject 80 mg subcut at week 2 | 3 x 80 mg/mL  | Autoinjectors<br>PFS | 0     |
|                                  | Weeks 4 - 10: Inject 80 mg subcut at week 4 and every two weeks thereafter through week 10  | 2 x 80 mg/mL  | Autoinjectors<br>PFS | 1     |
|                                  | Week 12 onwards: Inject 80 mg subcut at week 12 and every four weeks thereafter             | 1 x 80 mg/mL  | Autoinjectors<br>PFS | _____ |
| <b>Tremfya™<br/>(guselkumab)</b> | Inject 100 mg subcut at week 0  | 1 x 100 mg/mL | PFS                  | 0     |
|                                  | Inject 100 mg subcut at week 4 and every 8 weeks thereafter                                 | 1 x 100 mg/mL | PFS                  | _____ |
|                                  | Inject 100 mg subcut every 8 weeks  | 1 x 100 mg/mL | PFS                  | _____ |

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.