

Prescriber + Shipping 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: _____

Prescriber name: _____
 NPI: _____
 Address: _____
 Apt/Suite: _____ City: _____ State: _____ Zip: _____
 Contact: _____
 Phone: _____ Alternate: _____
 Fax: _____
 Email: _____
 If shipping to prescriber: First Fill Always 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®, Ilumya™, Orencia®, and Otezla® are listed alphabetically on respective forms §

Siliq™ (brodalumab)	Inject 210 mg subcut on weeks 0, 1, and 2 followed by 210 mg subcut every 2 weeks thereafter	4 x 210 mg/1.5 mL	PFS	0
	Inject 210 mg subcut every 2 weeks	2 x 210 mg/1.5 mL	PFS	_____
Simponi® (golimumab)	Psoriatic Arthritis: Inject 50 mg subcut once a month	1 x 50 mg/0.5 mL	PFS Autoinjector	_____
Simponi Aria® (golimumab)	Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at week 0	_____ x 50 mg/4 ml	Vials	0
	Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at week 4 and every 8 weeks thereafter	_____ x 50 mg/4 ml	Vials	_____
Stelara® (ustekinumab) <i>Adolescent - 12-17 years old</i>	Inject 0.75 mg/kg x _____ kg subcut on Day 1 (< 60 kg)	1 x 45 mg/0.5 mL	SDV	0
	Inject 45 mg subcut on Day 1 (60 to ≤ 100 kg)	1 x 45 mg/0.5 mL	PFS	
	Inject 90 mg subcut on Day 1 (> 100 kg)	1 x 90 mg/1 mL	_____	
	Inject 0.75 mg/kg x _____ kg subcut on Day 29 and every 12 weeks thereafter (< 60 kg)	1 x 45 mg/0.5 mL	SDV	_____
	Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (60 to ≤ 100 kg)	1 x 45 mg/0.5 mL	_____	
	Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (60 to ≤ 100 kg)	1 x 90 mg/1 mL	_____	_____
Stelara® (ustekinumab) 5 Xi`h	Inject 45 mg subcut on Day F1 ≤ 100 kgD	1 x 45 mg/0.5 mL	_____	0
	Inject J€ mg subcut on Day F QN 100 kgD	1 x 90 mg/1 mL	_____	
	Inject 45 mg subcut on Day 29 and every F2 weeks thereafter (≤ 100 kgD)	1 x 45 mg/0.5 mL	_____	
	Inject J€ mg subcut on Day 29 and every F2 weeks thereafter (N100 kgD)	1 x 90 mg/1 mL	_____	_____

§ Taltz®, Tremfya®, Xeljanz®, and Xeljanz® XR are listed alphabetically on respective 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.