Dermatology (drugs Si-St)

(Siliq™, Simponi®, Simponi Aria®,Stelara®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

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: _____
Please fax a copy of front and back of the insurance card(s).

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		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)** *Adolescent - 12-17 years old*	☐ 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	PFS	
	☐ Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (60 to ≤ 100 kg	☐ 1 x 90 mg/1 mL		
☐ **Stelara® (ustekinumab) Adult**	☐ Inject 45 mg subcut on Day 1 (≤ 100 kg)	☐ 1 x 45 mg/0.5 mL	PFS	0
	☐ Inject 90 mg subcut on Day 1 (> 100 kg)	☐ 1 x 90 mg/1 mL		
	☐ Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤ 100 kg)	☐ 1 x 45 mg/0.5 mL	PFS	_____
	☐ Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (> 100 kg)	☐ 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.

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