Dermatology (drugs T-Z)

Taltz®, Tremfya™, Xeljanz®, Xeljanz XR®

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®, Otezla®, Siliq™, Simponi®, Simponi Aria®, and Stelara® are listed on respective forms				
☐ **Taltz®** **(Ixekizumab)**	☐ **Psoriasis:** 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	☐PFS ☐ Autoinjector	0
	☐ **Psoriasis:** Weeks 4 - 10: Inject 80 mg subcut at week 4 and every two weeks thereafter through week 10	☐2 x 80 mg/mL	☐PFS ☐ Autoinjector	1
	☐ **Psoriasis:** Week 12 onwards: Inject 80 mg subcut at week 12 and every four weeks thereafter	☐ 1 x 80 mg/mL	☐PFS ☐ Autoinjector	____
	☐ **Psoriatic Arthritis:** Inject 160 mg (2 x 80 mg) subcut at week 0	☐ 2 x 80 mg/mL	☐PFS ☐Autoinjector	0
	☐ **Psoriatic Arthritis:** Inject 80 mg subcut at week 4 and every 4 weeks thereafter	☐ 1 x 80 mg/mL	☐ PFS ☐Autoinjector	____
☐ **Tremfya™** **(guselkumab)**	☐ 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	0
	☐ Inject 100 mg subcut every 8 weeks	☐ 1 x 100 mg/mL	PFS	____
☐ **Xeljanz®** **(tofacitinib)**	☐ Take 5 mg by mouth twice daily	☐ 60 x 5 mg	Tablets	____
☐ **Xeljanz® XR** **(tofacitinib)**	☐ Take 11 mg by mouth once daily	☐ 30 x 11 mg	Tablets	____
	Patients receiving Xeljanz®/Xeljanz® XR will be obtaining a non-biologic DMARD at: ☐ Diplomat (fill prescription below) ☐Other pharmacy ☐Not receiving (Reason:_____)			
☐ _____	☐ _____	_____	_____	_____

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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