

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:**  L20.\_\_\_\_ (Atopic Dermatitis)  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	PFS	Refill	
<b>Cimzia® (certolizumab)</b> <i>Psoriatic Arthritis</i>	Inject 400 mg subcut at weeks 0, 2 and 4	<input type="checkbox"/> 6 x 200 mg/mL	PFS Vials	0
	Inject 200 mg subcut every 2 weeks	2 x 200 mg/mL	PFS Vials	_____
	Inject 400 mg subcut every 4 weeks			
<b>Cimzia® (certolizumab)</b> <i>Plaque Psoriasis</i>	Inject 400 mg subcut every other week	2 x 200 mg/mL	PFS Vials	_____
	Inject 400 mg subcut at weeks 0, 2 and 4 (for some patients ≤ 90 kg)	6 x 200 mg/mL	PFS Vials	0
	Inject 200 mg subcut every other week (for some patients ≤ 90 kg)	2 x 200 mg/mL	PFS Vials	_____
<b>Cosentyx® (secukinumab)</b>	Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	4 x 150 mg/mL 8 x 150 mg/mL	Sensoready® Pen PFS	0
	Inject 150 mg subcut on week 4 and every 4 weeks thereafter Inject 300 mg subcut on week 4 and every 4 weeks thereafter	1 x 150 mg/mL 2 x 150 mg/mL	Sensoready® Pen PFS	_____
<b>Dupixent® (dupilumab)</b>	Inject 600 mg subcut on day 1	2 x 300 mg/2 mL	PFS	0
	Inject 300 mg subcut at day 15 and every 2 weeks thereafter	2 x 300 mg/2 mL	PFS	_____

**§Enbrel®, Humira®, Orencia®, Otezla®, Siliq™, Simponi®, Simponi Aria®, Stelara®, Taltz®, Tremfya™, Xeljanz® and Xeljanz® XR 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.