RX BIOTECH SPECIALTY PHARMACY
an aureus company

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Dermatology (A-O)

Cimzia®, Cosentyx®, Dupixent®, Enbrel®, Humira®, Odomzo®, Orencia®, Otezla®

Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:	Practice Name / Supervising MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: ◯ Psoriasis Vulgaris (L40.0) ◯ Other Psoriasis (L40.8) ◯ Psoriasis unspecified (L40.9) ◯ Psoriatic Arthritis (L40.5) ◯ Hidradenitis Suppurativa (L73.2) ◯ Chronic Urticaria (L50.8)				
◯ Atopic Dermatitis (L20.9)	TB/PDD Test Given? ◯ Y ◯ N	Date of Neg. Test: / /	HBV Positive? ◯ Y ◯ N	If yes, patient currently treated? ◯ Y ◯ N
Prior Treatment? ◯ Y ◯ N (Provide Information Below)	BSA affected (%):	Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other:		

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
Comorbidities:	Concomitant Medications:	Allergies: ◯ NKDA ◯ Other:	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **CIMZIA®** ◯ PFS ◯ Vials	◯ 1 starter kit (6x200mg/mL)	◯ **Starter Dose:** Inject 400 mg SQ at weeks 0, 2 and 4	**No Refills**
	◯ 1 carton (2x200mg/mL)	◯ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks ◯ **Maintenance Dose:** Inject 200 mg SQ every 2 weeks	
◯ **COSENTYX®** ◯ PFS ◯ Sensoready Pen®	◯ 4 cartons (8x150mg/mL) ◯ 4 cartons (4x150mg/mL)	◯ **Starter Dose:** Inject 300 mg SQ at weeks 0, 1, 2, and 3 ◯ **Starter Dose:** Inject 150 mg SQ at weeks 0, 1, 2, and 3	**No Refills**
	◯ 1 carton (2x150mg/mL) ◯ 1 carton (1x150mg/mL)	◯ **Maintenance Dose:** Inject 300 mg SQ every 4 weeks beginning on Day 29 ◯ **Maintenance Dose:** Inject 150 mg SQ every 4 weeks beginning on Day 29	
◯ **DUPIXENT®** ◯ PFS (with needle shield)	◯ 1 carton (2x300mg/2mL)	◯ **Starter Dose:** Inject 600mg SQ at week 0. Begin Maintenance Dose at week 2	**No Refills**
	◯ 1 carton (2x300mg/2mL)	◯ **Maintenance Dose:** Inject 300mg SQ at every 2 weeks	
◯ **ENBREL®** ◯ SureClick® ◯ PFS ◯ Vial	◯ 6 cartons (24x50mg/mL)	◯ **Starter Dose:** Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months	**No Refills**
	◯ 1 carton (4x50mg/mL)	◯ **Maintenance Dose:** Inject 50 mg SQ every week	
	◯ **PFS:** 1 carton (4x25mg/0.5mL) ◯ **Vial:** 1 carton (4x25mg/mL)	◯ **Pediatric Dose:** < 63 kg (138 lbs) Inject _____ mg (0.8mg/kg) SQ once a week ◯ **Pediatric Dose:** > 63 kg (138 lbs or more) Inject 50 mg SQ once a week	
◯ **HUMIRA®** (Plaque Psoriasis) ◯ Pens ◯ PFS	◯ **Pens Only:** Starter Kit (4x40mg/0.8mL)	◯ **Starter Dose:** Inject 80 mg SQ Day 1, then 40mg on day 8, then 1 pen every 2 weeks	**No Refills**
	◯ 1 carton (4x40 mg/0.8mL)	◯ **Maintenance Dose:** Inject 40 mg SQ every 2 weeks	
◯ **HUMIRA®** (Hidradenitis Suppurativa) ◯ Pens ◯ PFS	◯ **Pens Only:** Starter Kit (6x40mg/0.8mL)	◯ **Starter Dose:** Inject 160 mg SQ Day 1 (or 80 mg SQ on Day 1 and Day 2); then 80mg on Day 15.	**No Refills**
	◯ 2 cartons (4x40mg/0.8mL)	◯ **Maintenance Dose:** Inject 40mg SQ every week beginning on Day 29	
◯ **ODOMZO®** ◯ Capsule	◯ 200 mg capsule (30 capsules)	◯ Take 1 capsule (200 mg) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal	
◯ **ORENCIA®** ◯ Clickject® ◯ PFS ◯ Vial	◯ **Vials:** QS for starter dose	◯ **Starter Dose:** Infuse _____ mg IV in 100ml NS over 30 minutes at weeks 0 and 2	**No Refills**
	◯ **Pens/PFS:** 1 carton (4x125mg/ml) ◯ **Vials:** QS for maintenance dose	◯ **Maintenance Dose:** Inject 125 mg SQ once every week ◯ **Maintenance Dose:** Infuse _____ mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter	
◯ **OTEZLA®** ◯ Tablet	◯ 30 mg tablet (55 tabs for 28 Day Starter Pack)	◯ **Starter Dose:** Take as directed per package instructions	**No Refills**
	◯ 30 mg tablet (60 tablets)	◯ **Maintenance Dose:** Take 30 mg twice daily by mouth	

Injection Training

◯ Patient received injection training ◯ Prescriber's office to provide injection training ◯ RxBiotech to coordinate injection training

By signing this form and utilizing our services, you are authorizing RxBiotech and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: Date	Physician Signature: Date
Substitution Permitted	Dispense as Written