RX BIOTECH SPECIALTY PHARMACY
an aureus company

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www.RxBiotech.com

Dermatology (P-Z)

Siliq®, Simponi®, Stelara®,Tremfya®, Remicade®,

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
◯ **SILIQ®** ◯ PFS *Product is limited to certified prescribers enrolled in Siliq REMS	◯ 2 cartons (4x210mg/1.5mL)	◯ **Starter Dose:** Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks thereafter	**No Refills**
	◯ 1 carton (2x210mg/1.5mL)	◯ **Maintenance Dose:** Inject 210 mg SQ once every 2 weeks	
◯ **SIMPONI®** ◯ SmartJect® ◯ PFS	◯ 1 carton (1x50mg/0.5mL)	◯ Inject 50 mg SQ once a month	
◯ **STELARA®** ◯ PFS Patient eligible for self-injection? ◯ Yes ◯ No	◯ 1 carton (1x45mg/0.5mL) ◯ 1 carton (1x90mg/mL)	◯ **Starter Dose:** Inject 45 mg/0.5mL SQ on Day 1 (≤100 kg) ◯ **Starter Dose:** Inject 90 mg/1 mL SQ on Day 1 (>100 kg)	**No Refills**
		◯ **Maintenance Dose:** Inject 45mg/0.5mL SQ once every 12 weeks beginning on Day 29 (≤100kg) ◯ **Maintenance Dose:** Inject 90mg/mL SQ once every 12 weeks beginning on Day 29 (>100kg)	
◯ **TREMFYA®** ◯ PFS	◯ 2 cartons (2x100mg/mL)	◯ **Starter Dose:** Inject 100 mg SQ at week 0, 4 and every 8 weeks thereafter	**No Refills**
	◯ 1 carton (1x100mg/mL)	◯ **Maintenance Dose:** Inject 100 mg SQ every 8 weeks	
◯ **REMICADE®** ◯ Vial	◯ Number of 100mg vials _____ x3	◯ **Starter Dose:** Infuse _____mg IV over 2 hours at weeks 0, 2, and 6	**No Refills**
	◯ Number of 100mg vials _____	◯ **Maintenance Dose:** Infuse _____mg IV over 2 hours once every 8 weeks	
◯ Other:			

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