

Dermatology (drugs A-C)

(Cimzia®, Cosentyx®)



toll-free phone 855.611.3399
toll-free fax 855.423.8300

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: ☐ L20.9____ (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	Refill
Cimzia® (certolizumab) <i>Psoriatic Arthritis</i>	Inject 400 mg subcut at weeks 0, 2 and 4	6 x 200 mg/mL PFS Starter Kit Vials 0
	Inject 200 mg subcut every 2 weeks	2 x 200 mg/mL PFS Vials _____
	Inject 400 mg subcut every 4 weeks	
Cimzia® (certolizumab) <i>Plaque Psoriasis</i>	For some patients < 90 kg: Inject 400 mg subcut at weeks 0, 2, and 4, then 200 mg every 2 weeks	6 x 200 mg/mL PFS Starter Kit Vials 0
	Inject 400 mg subcut every 2 weeks	4 x 200 mg/mL PFS Vials _____
	Inject 200 mg subcut every 2 weeks	2 x 200 mg/mL PFS Vials _____
Cosentyx® (secukinumab)	Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3	Sensoready® Pen PFS 0
	Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	
	Inject 150 mg subcut on week 4 and every 4 weeks thereafter	Sensoready® Pen PFS _____
	Inject 300 mg subcut on week 4 and every 4 weeks thereafter	

Enbrel®, Dupixent®, Humira®, Ilumya™, Orencia®, Otezla®, Siliq™, Simponi®, Stelara®, Taltz®, Tremfya™, Xeljanz® and Xeljanz® XR are listed 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 Thrifty White Pharmacy 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 Thrifty White Pharmacy

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