Dermatology (drugs A-C)

(Cimzia®, Cosentyx®)

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient 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 + Shipping Information

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: ☐ 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 ☐ 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®** **(certolizumab)** *Psoriatic Arthritis*	☐ 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 ☐ Inject 400 mg subcut every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	_____
☐ **Cimzia®** **(certolizumab)** *Plaque Psoriasis*	☐ 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	☐ 4 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	0
	☐ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	☐ 8 x 150 mg/mL		
	☐ Inject 150 mg subcut on week 4 and every 4 weeks thereafter	☐ 1 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	_____
	☐ Inject 300 mg subcut on week 4 and every 4 weeks thereafter	☐ 2 x 150 mg/mL		

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

Reset Form