

Dermatology (drugs D-E)

(Dupixent®, Enbrel®)



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.____ (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
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\$ Cimzia®, Cosentyx® are listed alphabetically on respective forms \$

Dupixent® (dupilumab) <i>Adult</i>	Inject 600 mg subcut on day 1, then 300 mg at day 15 and every 2 weeks thereafter	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	_____
Dupixent® (dupilumab) <i>Adolescent (12-17)</i>	< 60 kg: Inject 400 mg subcut on day 1, then 200 mg at day 15 and every 2 weeks thereafter	2 x 200 mg/1.14 mL	PFS	0
	Inject 200 mg subcut at day 15 and every 2 weeks thereafter	2 x 200 mg/1.14 mL	PFS	_____
	≥ 60 kg: Inject 600 mg subcut on day 1, then 300 mg at day 15 and every 2 weeks thereafter	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® (etanercept) <i>Adult</i>	Inject 50 mg subcut twice a week (72-96 hours apart) for 3 months	8 x 50 mg/mL	SureClick® Autoinjector Mini™ Cartridge PFS	2
	Inject 50 mg subcut every week	4 x 50 mg/mL		_____
Enbrel® (etanercept) <i>Pediatric (4-17 yrs)</i>	Inject _____ mg (0.8mg/kg x _____kg subcut every week (≤ 63 kg))	_____ x 25 mg/0.5 mL	PFS	_____
		_____ x 25 mg	Vials	
	Inject 50 mg subcut every week (> 63 kg)	4 x 50 mg/mL	SureClick® Autoinjector Mini™ Cartridge PFS	_____

Humira®, Ilumya™, Orencia®, Otezla®, Siliq™, Simponi®, Stelara®, Taltz®, Tremfya™, Xeljanz® and Xeljanz® XR are listed alphabetically on respective forms
Simponi ARIA® is listed on the intravenous TNF-Alpha Inhibitor Form

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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