

Dermatology (drugs T-Z)

Taltz®, Tremfya™, Xeljanz®, Xeljanz XR®



toll-free phone 855.611.3399
toll-free fax 855.423.8300

| Prescriber + Shipping Information | |
|---|--|
| Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ | Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ 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: ☐ 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®, Cosentyx®, Dupixent®, Enbrel®, Humira®, Ilumya™, Orencia®, Otezla®, Siliq™, Simponi®, and Stelara® are listed on respective forms

| | | | | |
|--------------------------------------|---|---------------|-----------------------|-------|
| Taltz® (Ixekizumab) | Psoriasis: Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subcut at week 0, then inject 80 mg subcut at week 2 | 3 x 80 mg/mL | PFS Autoinjector | 0 |
| | Psoriasis: Weeks 4 - 10: Inject 80 mg subcut at week 4 and every two weeks thereafter through week 10 | 2 x 80 mg/mL | PFS Autoinjector | 1 |
| | Psoriasis: Week 12 onwards: Inject 80 mg subcut at week 12 and every four weeks thereafter | 1 x 80 mg/mL | PFS Autoinjector | _____ |
| | Psoriatic Arthritis: Inject 160 mg (2 x 80 mg) subcut at week 0 | 2 x 80 mg/mL | PFS Autoinjector | 0 |
| | Psoriatic Arthritis: Inject 80 mg subcut at week 4 and every 4 weeks thereafter | 1 x 80 mg/mL | PFS Autoinjector | _____ |
| Tremfya™ (guselkumab) | Inject 100 mg subcut at week 0 | 1 x 100 mg/mL | PFS Autoinjector | 0 |
| | Inject 100 mg subcut at week 4 and every 8 weeks thereafter | 1 x 100 mg/mL | PFS Autoinjector | 0 |
| | Inject 100 mg subcut every 8 weeks | 1 x 100 mg/mL | PFS Autoinjector | _____ |
| Xeljanz® (tofacitinib) | Take 5 mg by mouth twice daily | 60 x 5 mg | Tablets | _____ |
| Xeljanz® XR (tofacitinib) | Take 11 mg by mouth once daily | 30 x 11 mg | Tablets | _____ |

Patients receiving Xeljanz®/Xeljanz® XR will be obtaining a non-biologic DMARD at:
 Diplomat (fill prescription below) Other pharmacy Not receiving (Reason: _____)

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

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 855-611-3399 or by emailing specialty@thriftywhite.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.