Dermatology

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

☐ New Patient

Date

Patient Name_____DOB_____Weight_____ ☐ Male ☐ Female
Street Address:_____Apt #_____City_____State_____Zip_____
Phone #_____Cell #_____Allergies_____

Medical Assessment (Use this area or attach patient labs and other authorization information)

Diagnosis: ❑ L20.9 Atopic Dermatitis ❑ L40.8 Moderate to Severe Plaque Psoriasis ❑ L40.50 Psoriatic Arthritis ❑ L73.2 Hidradenitis Suppurativa - Hurley Stage _____
❑ Other: Dx code_____ Condition_____
Drug Allergies:_____
Location: % BSA: _____ ❑ Hands ❑ Feet ❑ Scalp ❑ Groin ❑ Nails ❑ Other:_____
Prior Failed Meds: ❑ Biologics ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Orencia ❑ Remicade ❑ Rituxan ❑ Simponi ❑ Stelara
❑ MTX ❑ Soriatane ❑ CYA Length of Treatment _____ Reason for Discontinuing_____
❑ PUVA/UVB Length of Treatment _____ Reason for Discontinuing_____
❑ Topicals Length of Treatment _____ Inadequate Response List Specific Names _____
❑ Contraindicated Medication _____ Reason _____
Does patient have a latex allergy? ❑ Yes ❑ No TB/PPD Test given or intended to be given before start ❑ Yes ❑ No

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Cosentyx®	❑ 300mg (2x150) Pen ❑ PFS ❑ 150mg Pen ❑ PFS	❑ Load: Inject ❑ 300mg or ❑ 150mg subcutaneously week 0, 1, 2, 3, 4 ❑ Maintenance: Inject ❑ 300mg or ❑ 150mg subcutaneously every 4 weeks	10 4 week supply	none _____
❑ Dupixent®	❑ 300 mg/2 mL PFS w/ shield ❑ 300 mg/2 mL PFS w/o shield	❑ Load: Inject 600mg (2-300mg injections in different injection sites) on Day 1, then 300 mg on Day 15, then 300 mg every other week ❑ Maintenance: Inject 300 mg subcutaneously every other week	4 syringes 2 syringes	none _____
❑ Enbrel® Wt: _____	❑ 50mg Sureclick ❑ 50mg Prefilled Syringe ❑ 25mg Prefilled Syringe ❑ 25mg Vials	❑ Inject 50mg subcutaneously **TWICE** a week 72-96 hours apart ❑ Inject 50mg subcutaneously **ONCE** a week ❑ Inject 25mg subcutaneously **TWICE** a week 72-96 hours apart ❑ Inject 2-25mg (50mg) on same day **TWICE** a week 72-96 hours apart ❑ Inject 0.8mg/kg (_____mg) subcutaneously **ONCE** a week	4 week supply	_____
❑ Erivedge®	❑ 150mg capsule	❑ Take one capsule by mouth daily	4 week supply	_____
❑ Humira®	❑ Psoriasis Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe	❑ Inject 2-40mg (80mg) on Day 1, then 40mg on Day 8, then 40mg every other week ❑ Inject 40mg subcutaneously **EVERY OTHER** week ❑ Inject 40mg subcutaneously **ONCE** a week	Loading Dose 4 week supply	none _____
❑ Humira® HS	❑ HS Starter Package ❑ 40 mg pen ❑ 40mg Prefilled Syringe	160mg given as ❑ Four 40mg SubQ day 1 OR ❑ Two 40mg SubQ days 1 & 2 then Week 2 inject 80mg (Two 40mg injections) subcutaneously on day 15 ❑ Week 4 +: Inject 40mq SQ weekly	Loading Dose 4 week supply	none _____
❑ Odomzo®	200mg capsule	Take one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal	30	_____
❑ Otezla®	❑ Starter Pack ❑ 30mg Tablets	❑ Titrate: Take 1 tablet on day 1 then twice daily as directed **OR date provided** _____ ❑ Maintenance: Take 1 tablet by mouth twice daily. ❑ Bridge Rx: Take 1 tablet by mouth twice daily; dispensed by OSP	1 Starter Pack 60 28	none _____ 12
❑ Remicade® Wt: _____	100mg Vial	❑ Infuse _____mg at week 0, 2, 6 ❑ Infuse _____mg at every _____ weeks	Loading dose _____	none _____
❑ Simponi®	❑ 50mg SmartJect ❑ PFS	Inject 50mg subcutaneously once a month as directed	4 week supply	_____
❑ Stelara® Wt: _____	❑ 45mg Prefilled Syringe ❑ 90mg Prefilled Syringe	❑ Inject 45mg on day 0, then week 4, then every 12 weeks (**for Patients ≤ 220 lbs**) ❑ Inject 90mg on day 0, then week 4, then every 12 weeks (**for Patients > 220 lbs**)	4 week supply 4 week supply	_____ _____
❑ Taltz™	❑ 80mg/mL Autoinjector ❑ 80mg/mL Prefilled Syringe	❑ Load: Inject 160mg (2 – 80mg) subcutaneously week 0, then inject 80mg week 2 then Inject 80mg every 2 weeks (weeks 4-10) then Inject 80mg at week 12 ❑ Maintenance Dose: Inject 80 mg every 4 weeks	3 2 1 1	none 1 none _____

℞

ALL controlled substance quantities must be hand written in number and letter form

Prescriber's Name _____ Office Contact_____
Street Address _____Suite #_____ City _____ State _____ Zip _____
Telephone_____ License # _____ NPI # _____ DPS # _____ DEA #_____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

Please fax completed form to 1 (888) 294-9434