DERMATOLOGY

SPECIALTY PHARMACY

New Orleans, LA **toll free** 888.355.4191 **toll free fax** 888.355.4192

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ **SHIP TO:** ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name

Address

City, State, Zip

Main Phone Alternate Phone

Social Security #

Date of Birth ❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name

DEA # NPI # License #

Address

City, State, Zip

Phone Fax

Contact Person

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL 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 biologic started)? ❑ Yes ❑ No (PLEASE send LAB result)

	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	5 week supply 4 week supply	none _____
❑ Dupixent®	300mg/2 mL PFS w/ shield	❑ Load: Inject 600mg (2-300mg injections in different injection sites) on Day 1, then 300mg on Day 15, then 300mg every other week ❑ Maintenance: Inject 300mg 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 ❑ 40mg 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 _____
❑ Siliq®	210mg Prefilled Syringe	❑ Load: Inject 210mg subcutaneously at weeks 0, 1 and 2 and then every 2 weeks ❑ Maintenance: Inject 210mg subcutaneously every 2 weeks	4 syringes 2 syringes	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**)	1 1	_____ _____
❑ Taltz™	❑ 80mg/mL Autoinjector ❑ 80mg/mL Prefilled Syringe	❑ Load: Inject 160mg (2 – 80mg) subcutaneously on 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 80mg every 4 weeks	3 2 1 1	none 1 none _____
❑ Tremfya™	100mg/ml Prefilled Syringe	❑ Load: Inject 100mg subcutaneously on week 0 and on week 4 ❑ Maintenance: Inject 100mg subcutaneously every 8 weeks	1 1	_____ _____
❑ Other			_____	_____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date

Prescriber's Signature (no stamps) Dispense As Written Date