



SPECIALTY PHARMACY

DERMATOLOGY

Lake Mary, FL toll free

fax

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER _____

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	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**

<input type="checkbox"/> Cosentyx*	300mg (2x150) <input type="checkbox"/> Pen <input type="checkbox"/> PFS 150mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Load: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg subcutaneously week 0, 1, 2, 3, 4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg subcutaneously every 4 weeks	5 week supply 4 week supply	none _____
<input type="checkbox"/> Dupixent*	300mg/2 mL PFS w/ shield	<input type="checkbox"/> Load: Inject 600mg (2-300mg injections in different injection sites) on Day 1, then 300mg on Day 15, then 300mg every other week <input type="checkbox"/> Maintenance: Inject 300mg subcutaneously every other week	4 syringes 2 syringes	none _____
<input type="checkbox"/> Enbrel*	<input type="checkbox"/> 50mg Sureclick <input type="checkbox"/> 50mg Prefilled Syringe <input type="checkbox"/> 25mg Prefilled Syringe <input type="checkbox"/> 25mg Vials Wt: _____	<input type="checkbox"/> Inject 50mg subcutaneously TWICE a week 72-96 hours apart <input type="checkbox"/> Inject 50mg subcutaneously ONCE a week <input type="checkbox"/> Inject 25mg subcutaneously TWICE a week 72-96 hours apart <input type="checkbox"/> Inject 2-25mg (50mg) on same day TWICE a week 72-96 hours apart <input type="checkbox"/> Inject 0.8mg/kg (_____mg) subcutaneously ONCE a week	4 week supply	_____
<input type="checkbox"/> Erivedge*	150mg capsule	Take one capsule by mouth daily	4 week supply	_____
<input type="checkbox"/> Humira*	<input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> Inject 2-40mg (80mg) on Day 1, then 40mg on Day 8, then 40mg every other week <input type="checkbox"/> Inject 40mg subcutaneously EVERY OTHER week <input type="checkbox"/> Inject 40mg subcutaneously ONCE a week	Loading Dose 4 week supply	none _____
<input type="checkbox"/> Humira* HS	<input type="checkbox"/> HS Starter Package <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe	160mg given as <input type="checkbox"/> Four 40mg SubQ day 1 OR <input type="checkbox"/> Two 40mg SubQ days 1 & 2 then week 2 inject 80mg (Two 40mg injections) subcutaneously on day 15 <input type="checkbox"/> Week 4 +: Inject 40mg SQ weekly	Loading Dose 4 week supply	none _____
<input type="checkbox"/> Odomzo*	200mg capsule	Take one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal	30	_____
<input type="checkbox"/> Otezla*	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Titrate: Take 1 tablet on day 1 then twice daily as directed OR date provided _____ <input type="checkbox"/> Maintenance: Take 1 tablet by mouth twice daily. <input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth twice daily; dispensed by OSP	1 Starter Pack 60 28	none _____ 12
<input type="checkbox"/> Remicade* Wt: _____	100mg Vial	<input type="checkbox"/> Infuse _____mg at week 0, 2, 6 <input type="checkbox"/> Infuse _____mg at every _____ weeks	Loading dose	none _____
<input type="checkbox"/> Siliq*	210mg Prefilled Syringe	<input type="checkbox"/> Load: Inject 210mg subcutaneously at weeks 0, 1 and 2 and then every 2 weeks <input type="checkbox"/> Maintenance: Inject 210mg subcutaneously every 2 weeks	4 syringes 2 syringes	none _____
<input type="checkbox"/> Simponi*	50mg <input type="checkbox"/> SmartJect <input type="checkbox"/> PFS	Inject 50mg subcutaneously once a month as directed	4 week supply	_____
<input type="checkbox"/> Stelara* Wt: _____	<input type="checkbox"/> 45mg Prefilled Syringe <input type="checkbox"/> 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	_____ _____
<input type="checkbox"/> Taltz™	<input type="checkbox"/> 80mg/mL Autoinjector <input type="checkbox"/> 80mg/mL Prefilled Syringe	<input type="checkbox"/> 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 <input type="checkbox"/> Maintenance Dose: Inject 80mg every 4 weeks	3 2 1 1	none 1 none _____
<input type="checkbox"/> Tremfya™	100mg/ml Prefilled Syringe	<input type="checkbox"/> Load: Inject 100mg subcutaneously on week 0 and on week 4 <input type="checkbox"/> Maintenance: Inject 100mg subcutaneously every 8 weeks	1 1	_____ _____
<input type="checkbox"/> Other				

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Prescriber's Signature (no stamps)

Substitution Permitted

Date

Prescriber's Signature (no stamps)

Dispense As Written

Date

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