Dermatology (drugs F-R)

Humira®, Ilumya™, Orencia®, Otezla®

For Remicade® (Infliximab) products and Simponi ARIA®, see Intravenous TNF-Alpha Inhibitor Form

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

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 ☐ Yes ☐ 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® are listed alphabetically on respective enrollment forms.§				
☐ **Humira®** **(adalimumab)**	☐ **Plaque Psoriasis (Adult) OR Hidradenitis Suppurativa (Adolescents 12 yrs and older (30 kg to < 60 kg) Starter Dose:** Inject 80 mg subcut day 1, then 40 mg on day 8, then 40 mg every 2 weeks thereafter	☐ 1 x 80 mg/0.8 mL+ 2 x 40 mg/0.4 mL **CF**	Starter Kit Pens	0
		☐ 4 x 40 mg/0.8 mL	Starter Kit Pens	0
		☐ 4 x 40 mg/0.4 mL **CF**	☐ PFS ☐ Pens	
	☐ **Plaque Psoriasis (Adult) OR Hidradenitis Suppurativa Adolescents 12 yrs and older (30 kg to < 60 kg) Maintenance:** Inject 40 mg subcut every 2 weeks	☐ 2 x 40 mg/0.8 mL	☐ PFS ☐ Pens	_____
		☐ 2 x 40 mg/0.4 mL **CF**		
	☐ **Hidradenitis Suppurativa (Adult) OR Adolescents 12 years and older (≥ 60 kg) Starter:** Inject 160 mg subcut on day 1, 80 mg on day 15, then 40 mg on day 29 and once weekly thereafter	☐ 3 x 80 mg/0.8 mL **CF**	Starter Kit Pens	0
	☐ **Hidradenitis Suppurativa Adults OR adolescents 12 years and older (≥ 60 kg) Maintenance**: Inject 40 mg subcut on day 29 and once every week thereafter	☐ 4 x 40 mg/0.8 mL	☐ PFS ☐ Pens	_____
		☐ 4 x 40 mg/0.4 mL **CF**		
☐ **Ilumya™** **(tildrakizumab-asmn)**	☐ Inject 100 mg subcut at week 0, 4, and every 12 weeks thereafter	1 x 100 mg/1 mL	PFS	_____
☐ **Orencia®** **(abatacept)** Psoriatic Arthritis	☐ Infuse_____ mg at week 0 and 2	_____ x 250 mg/mL	SDV	0
	☐ Infuse_____ mg at week 4 and every 4 weeks thereafter <60 kg = 500 mg, 60 to 100 kg = 750 mg, > 100 kg = 1000 mg	_____ x 250 mg/mL	SDV	_____
	☐ Inject 125 mg subcut once weekly	4 x 125 mg/mL	☐ PFS ☐ Autoinjector	_____
☐ **Otezla®** **(apremilast)**	☐ Take as directed per package instructions	55 tablets	28-day starter pack	0
	☐ Take 30 mg by mouth twice daily	60 x 30 mg	Tablets	_____
§ Siliq™, Simponi®, Stelara®, Taltz®, Tremfya™, Xeljanz® and Xeljanz® XR are listed alphabetically on respective enrollment forms.§				

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.

Reset Form