

Dermatology (drugs Si-St)

(Siliq™, Simponi®, Skyrizi™, Stelara®)

For Simponi ARIA®, see Intravenous TNF-Alpha Inhibitor Form



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Prescriber + Shipping 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: _____

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ 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®, and Otezla® are listed alphabetically on respective forms §

| | | | | |
|---|--|------------------------------------|------------------|-------|
| Siliq™ (brodalumab) | Inject 210 mg subcut on weeks 0, 1, and 2 followed by 210 mg subcut every 2 weeks thereafter | 4 x 210 mg/1.5 mL | PFS | 0 |
| | Inject 210 mg subcut every 2 weeks | 2 x 210 mg/1.5 mL | PFS | _____ |
| Simponi® (golimumab) | Psoriatic Arthritis: Inject 50 mg subcut once a month | 1 x 50 mg/0.5 mL | PFS Autoinjector | _____ |
| Skyrizi™ (risankizumab-rzaa) | Inject 150 mg subcut at week 0, week 4, then every 12 weeks thereafter | 2 x 75 mg/0.83 mL | PFS | 0 |
| | Inject 150 mg subcut at week 4 then every 12 weeks thereafter | 2 x 75 mg/0.83 mL | PFS | _____ |
| Stelara® (ustekinumab) Adolescent - 12-17 years old | Inject 0.75 mg/kg x _____ kg subcut on Day 1 (<60kg) | 1 x 45 mg/0.5 mL | SDV | 0 |
| | Inject 45 mg subcut on Day 1 (60 to ≤ 100 kg) | 1 x 45 mg/0.5 mL | PFS | |
| | Inject 90 mg subcut on Day 1 (> 100 kg) | 1 x 90 mg/1 mL | | |
| | Inject 0.75 mg/kg x _____ kg subcut on Day 29 and every 12 weeks thereafter (< 60 kg) | 1 x 45 mg/0.5 mL | SDV | _____ |
| | Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (60 to ≤ 100 kg) Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (60 to ≤ 100 kg) | 1 x 45 mg/0.5 mL 1 x 90 mg/1 mL | úøù | |
| Stelara® (ustekinumab) 5 Xi`h | Inject 45 mg subcut on Day F 100 kgD | 1 x 45 mg/0.5 mL | úøù | 0 |
| | Inject J€ mg subcut on Day F Q 100 kgD | 1 x 90 mg/1 mL | | |
| | Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤ 100 kg) Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (> 100 kg) | 1 x 45 mg/0.5 mL 1 x 90 mg/1 mL | úøù | _____ |

§ Taltz®, Tremfya®, Xeljanz®, and Xeljanz® XR are listed alphabetically on respective 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

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