P: 832-813-8932

F: 888-883-9901

DERMATOLOGY RX FORM

REFILLS
- ☐ 1 YEAR
- ☐ ______

PATIENT INFORMATION

PATIENT NAME: ______________________________ DOB _________/_________/_______ PHONE: (________) - _________ - _________

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

MEDICATION

- ☐ CIMZIA 400MG SQ AT WEEKS 0, 2, AND 4 AND EVERY 4 WEEKS
- ☐ CIMZIA ___________ MG SQ EVERY ___________ WEEKS

- ☐ ILUMYA 100MG SQ AT WEEKS 0, 4, AND EVERY 12 WEEKS
- ☐ ILUMYA 100 MG SQ EVERY 12 WEEKS

- ☐ REMICADE _______MG/KG IV AT WEEKS 0, 2, 6, AND EVERY 8 WEEKS
- ☐ REMICADE _______MG/KG IV EVERY ____________ WEEKS

*PREMEDICATE: TYLENOL 500MG PO, ZYRTEC 10MG PO

- ☐ STELARA 45MG SQ AT WEEK 0, 4, AND EVERY 12 WEEKS (<220LBS)
- ☐ STELARA 90MG SQ AT WEEK 0, 4, AND EVERY 12 WEEKS (>220LBS)

- ☐ DUPIXENT 600MG SQ AT WEEK 0, 300MG SQ AT WEEK 2
- ☐ DUPIXENT 300MG SQ EVERY OTHER WEEK

- ☐ SIMPONI ARIA 2MG/KG IV AT WEEKS 0, 4, AND THEN EVERY 8 WEEKS
- ☐ SIMPONI ARIA 2MG/KG IV EVERY 8 WEEKS

- ☐ XOLAIR 150MG SQ EVERY 4 WEEKS
- ☐ XOLAIR 300MG SQ EVERY 4 WEEKS

- ☐ RITUXAN 1000MG IV AT DAY 0 AND DAY 15
- ☐ RITUXAN 500MG IV AT MONTH 12 AND EVERY 6 MONTHS

*PREMEDICATE: SOLUMEDROL 100MG IV, TYLENOL 500MG PO, BENADRYL 25MG PO (30 MIN PRIOR)

PRE-MEDICATIONS

BENADRYL IV __________ MG
REGLAN IV __________ MG
SOLUMEDROL IV __________ MG
ZOFRAN IV __________ MG
OTHER IV ________________________________ MG

BENADRYL PO __________ MG
TYLENOL PO __________ MG
ZYRTEC PO __________ MG
ZOFRAN PO __________ MG
ZANTAC PO __________ MG
OTHER PO ____________________________________ MG

IF APPLICABLE, DATE OF LAST INFUSION: _________________

WILL PATIENT BE RE-LOADING? ☐ YES ☐ NO

MEDICAL INFORMATION

WEIGHT: ____________LBS HEIGHT: _____________ IN
ALLERGIES: ____ ☐ N.K.D.A

DATE OF TB EXAM (CIMZIA, REMICADE, STELARA, ILUMYA): ____________

METHOD: ☐ CXR ☐ QFT ☐ PPD
RESULT: ☐ NEGATIVE ☐ POSITIVE

DATE OF HEP PANEL (CIMZIA, REMICADE, RITUXAN, SIMPONI ARIA): _________

RESULT: ☐ NEGATIVE ☐ POSITIVE

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 _________________________________ DATE RANGE: _____________
#2 _________________________________ DATE RANGE: _____________
#3 _________________________________ DATE RANGE: _____________

PATIENT WILL BE DISCONTINUING: _______________________________

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

DIAGNOSIS

- ☐ L10.0 PEMPHIGUS VULGARIS
- ☐ L40.0 PSORIASIS VULGARIS
- ☐ L50.1 CHRONIC IDIOPATHIC URTICARIA
- ☐ L20.9 ATOPIC DERMATITIS, UNSPECIFIED
- ☐ L20.81 ATOPIC NEURODERMATITIS
- ☐ L20.82 FLEXURAL ECZEMA
- ☐ L20.84 INTRINSIC (ALLERGIC) ECZEMA
- ☐ L20.0 BESNIER'S PRURIGO
- ☐ L40.50 ARTHROPATHIC PSORIASIS, UNSPECIFIED
- ☐ L40.51 DISTAL INTERPHALANGEAL PSORIATIC ARTHROPATHY
- ☐ L40.52 PSORIATIC ARTHRITIS MUTILANS
- ☐ L40.53 PSORIATIC SPONDYLITIS
- ☐ L40.54 PSORIATIC JUVENILE ARTHROPAHY
- ☐ L40.59 OTHER PSORIATIC ARTHROPATHY

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): ______________________________________ NPI: ______________________________

PHONE: ___________________________ FAX: ________________________ CONTACT PERSON: ______________________

PHYSICIAN NAME (SIGNED): ______________________________________ DATE: ______________________________

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