DERMATOLOGY

APEX SPECIALTY PHARMACY

Benefit Investigation + Prior Authorization Support

Date _____

Ship to:: ☐ Patient ☐ Provider

PATIENT INFORMATION::

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10) ☐ L20. ____ Atopic Dermatitis ☐ C44.____ Basal Cell Carcinoma ☐ L73.2 Hidradenitis Suppurativa

☐ L74.51 ____ Hyperhidrosis ☐ L40. ____ Plaque Psoriasis ☐ L40. ____ Psoriatic Arthritis ☐ L50.____ Urticaria

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION::

Tried/Failed Therapies: ☐ Cimzia ☐ Cosentyx ☐ Cyclosporine ☐ Enbrel ☐ Humira ☐ Ilumya ☐ Methotrexate ☐ Orencia ☐ Otezla ☐ PUVA/UVB ☐ Remicade ☐ Simponi ☐ Soriatane ☐ Stelara ☐ Taltz ☐ Topicals

BSA:: _____% ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Other Areas _____

PPD/Chest X-Ray for TB? ☐ Yes ☐ No Drug Allergies: _____

PRESCRIPTION INFORMATION::

☐ Cimzia	☐ 200x2 PFS ☐ 200x2 LYO	☐ Start: Inject 400mg SQ at weeks 0, 2, and 4 (qty 3 kits) ☐ Maint: Inject ____mg SQ every: ☐ 2 ☐ 4 wks (qty ____) ***Pt. weight ____ lbs***	Refill: 0 Refill:
☐ Cosentyx	☐ 150mg Sensoready PEN ☐ 150mg PFS	☐ Start: Inject 2-150mg (300mg) SQ at Weeks 0, 1, 2, 3, and 4 (qty ____) ☐ Maint: Inject 2-150mg (300mg) SQ every 4 weeks (qty 2)	Refill: 0 Refill:
☐ Dupixent	☐ 300mg PFS	☐ Start: Inject 2-300mg (600mg) SQ in different injection sites at Week 0 (qty 2) ☐ Maint: Inject 300mg every other week (qty 2)	Refill: 0 Refill:
☐ Enbrel	☐ 50mg Enbrel Mini ☐ 50mg Sureclick ☐ 50mg PFS ☐ 0.8 mg/kg	☐ Inject 50mg SQ TWICE a week, 72-96 hours apart (qty 8) ☐ Inject 50mg SQ ONCE a week (qty 4) ☐ Inject 0.8 mg/kg ONCE a week (qty 4) ***Pt. weight ____ lbs***	Refill:
☐ Erivedge	☐ 150mg Capsule	Take 1 capsule by mouth daily (qty 30)	Refill:
☐ Humira Starter Kit ***citrate free***	☐ 40mg/0.8ml PEN (qty 4) ☐ 40mg/0.8ml PEN (qty 6) ☐ 80mg/0.8ml (qty 1) and 40/0.4ml PEN* (qty 2) ☐ 80mg/0.8ml PEN* (qty 3)	☐ Inject 80mg SQ on Day 1, then 40mg SQ on Day 8, then 40mg every other week ☐ Inject 160mg SQ on Day 1 or 80mg per day on Days 1 and 2, then 80mg on Day 15, then 40mg every week	Refill: 0
☐ Humira Maintenance ***citrate free***	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml PEN* ☐ 40mg/0.4ml PFS*	☐ Inject 40mg SQ every-other-week (qty 2) ☐ Inject 40mg SQ ONCE a week (qty 4)	Refill:
☐ Ilumya	☐ 100mg/ml PFS	☐ Start: Inject 100mg SQ at week 0 and week 4, then every 12 weeks (qty 2)	Refill:
☐ Odomzo	☐ 200mg Capsule	☐ Take 1 Capsule ONCE daily on an empty stomach (qty 30)	Refill:
☐ Otezla	☐ Starter Kit ☐ 30mg Tablet	☐ Take Starter Dosing per instructions (qty 55 // 28 days) [☐ *Office provided*] ☐ Take 1 tablet by mouth twice daily (qty 60 // 30 days)	Refill: 0 Refill:
☐ Otrexup ☐ Rasuvo	☐ _____mg	☐ Inject _____mg SQ once weekly	Refill:
☐ Simponi	50mg ☐ SmartJect ☐ PFS	☐ Inject 50mg SQ ONCE a MONTH as directed (qty 1)	Refill:
☐ Sivextro	☐ 200mg Tablet	☐ Take 1 Tablet ONCE daily (qty 6)	Refill:
☐ Stelara	☐ 45mg PFS ☐ 90mg PFS	☐ Start: Inject ____mg SQ day 0, then on day 28 (qty 2) ☐ Maint: Inject ____mg SQ every 12 weeks (qty 1) ***Pt. weight _____lbs***	Refill: 0 Refill:
☐ Taltz	☐ 80mg Autoinjector ☐ 80mg PFS	☐ Start: Inject 160mg SQ at Week 0, then 80mg at Weeks 2, 4, 6, 8, 10, 12 (qty 8) ☐ Maint: Inject 80mg SQ every 4 weeks (qty 1)	Refill: 0 Refill:
☐ Tremfya	☐ 100mg PFS	☐ Start: Inject 100mg SQ at Week 0, then on day 28 (qty 2) ☐ Maint: Inject 100mg SQ every 8 weeks (qty 1)	Refill: 0 Refill:

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Phone: 855.257.2584 || Fax: 866.680.3539