APEX SPECIALTY PHARMACY

# DERMATOLOGY

**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::

| Drug | Product | Directions | Refill |
|---|---|---|---|
| ☐ Cimzia | ☐ 200x2 PFS<br>☐ 200x2 LYO | ☐ Start: Inject 400mg SQ at weeks 0, 2, and 4 (qty 3 kits)<br>☐ Maint: Inject ____mg SQ every: ☐ 2 ☐ 4 wks (qty ____) ***Pt. weight ____ lbs*** | Refill: 0<br>Refill: |
| ☐ Cosentyx | ☐ 150mg Sensoready PEN<br>☐ 150mg PFS | ☐ Start: Inject 2-150mg (300mg) SQ at Weeks 0, 1, 2, 3, and 4 (qty ____)<br>☐ Maint: Inject 2-150mg (300mg) SQ every 4 weeks (qty 2) | Refill: 0<br>Refill: |
| ☐ Dupixent | ☐ 300mg PFS | ☐ Start: Inject 2-300mg (600mg) SQ in different injection sites at Week 0 (qty 2)<br>☐ Maint: Inject 300mg every other week (qty 2) | Refill: 0<br>Refill: |
| ☐ Enbrel | ☐ 50mg Enbrel Mini<br>☐ 50mg Sureclick<br>☐ 50mg PFS<br>☐ 0.8 mg/kg | ☐ Inject 50mg SQ TWICE a week, 72-96 hours apart (qty 8)<br>☐ Inject 50mg SQ ONCE a week (qty 4)<br>☐ 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<br>**citrate free* | ☐ 40mg/0.8ml PEN (qty 4)<br>☐ 40mg/0.8ml PEN (qty 6)<br>☐ 80mg/0.8ml (qty 1) and 40/0.4ml PEN* (qty 2)<br>☐ 80mg/0.8ml PEN* (qty 3) | ☐ Inject 80mg SQ on Day 1, then 40mg SQ on Day 8, then 40mg every other week<br>☐ 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<br>**citrate free* | ☐ 40mg/0.8ml PEN<br>☐ 40mg/0.8ml PFS<br>☐ 40mg/0.4ml PEN*<br>☐ 40mg/0.4ml PFS* | ☐ Inject 40mg SQ every-other-week (qty 2)<br>☐ 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<br>☐ 30mg Tablet | ☐ Take Starter Dosing per instructions (qty 55 // 28 days) [ ☐ *Office provided*]<br>☐ Take 1 tablet by mouth twice daily (qty 60 // 30 days) | Refill: 0<br>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<br>☐ 90mg PFS | ☐ Start: Inject ____mg SQ day 0, then on day 28 (qty 2)<br>☐ Maint: Inject ____mg SQ every 12 weeks (qty 1) ***Pt. weight ______lbs*** | Refill: 0<br>Refill: |
| ☐ Taltz | ☐ 80mg Autoinjector<br>☐ 80mg PFS | ☐ Start: Inject 160mg SQ at Week 0, then 80mg at Weeks 2, 4, 6, 8, 10, 12 (qty 8)<br>☐ Maint: Inject 80mg SQ every 4 weeks (qty 1) | Refill: 0<br>Refill: |
| ☐ Tremfya | ☐ 100mg Autoinjector<br>☐ 100mg PFS | ☐ Start: Inject 100mg SQ at Week 0, then on day 28 (qty 2)<br>☐ Maint: Inject 100mg SQ every 8 weeks (qty 1) | Refill: 0<br>Refill: |

PRESCRIBER SIGNATURE ______________________________ ______________________________ DATE ____ / ____ / ____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Phone: 855.257.2584 || Fax: 866.680.3539