TruCare PHARMACY

Phone: (844) 446-0808 | Fax: 951-817-1020

DERMATOLOGY MEDICATION FORM

Date Shipment Needed: _____

Ship To: ☐ Patient ☐ Physician ☐ Nursing Needs ☐ Training needed

Patient Name (Required):			Physician Name:		Title:
DOB (Required):	Sex: ☐ M ☐ F	Weight: ☐ lbs. ☐ Kg	Supervising Physician:		
Address:			LIC#:	DEA#:	NPI#:
City:	State:	Zip:	Clinic Location:	Phone:	Fax:
Home Phone:	Cell Phone:		Address:		
Known Allergies:			City:	State:	Zip:

PLEASE ATTACH DEMOGRAPHIC INFORMATION / INSURANCE INFORMATION INCLUDING: MEDICAL CARD & PRESCRIPTION CARD COPY FRONT/BACK

DIAGNOSIS & STATEMENT OF MEDICAL NECESSITY

☐ L40.0 Psoriasis ☐ L40.1; L40:2, L40:3, L40:4, L40.8, L40.54 Psoriatic arthritis ☐ L40.59 ☐ L73.2 Hidradenitis Suppurativa ☐ Other ICD-10 Code _____

- Location: ☐ Hands ☐ Feet ☐ Face ☐ Scalp ☐ Groin ☐ Nails ☐ Others_____
- Severity: ☐ Mild (up to 3% BSA) ☐ Moderate (3%-10% BSA) ☐ Severe (greater than 10% BSA), BSA_____%
- Location: ☐ Hands ☐ Feet ☐ Face ☐ Scalp ☐ Groin ☐ Nails ☐ Others_____
- Has patient been treated previously for this condition? ☐ Yes ☐ No , Medication / therapy failed (length of therapy):

  ☐ Topical _____ ☐ Light therapy_____ ☐ Methotrexate_____ ☐ Soriatane _____ ☐ Cyclosporine _____

  ☐ Enbrel _____ ☐ Humira_____ ☐ Remicade_____ ☐ Amevive _____ ☐ Raptiva _____

  ☐ Rituxan _____ ☐ IVIG_____ ☐ Simponi_____ ☐ Stelara _____ ☐ Other _____
- Is patient currently on therapy? ☐ Yes ☐ No Type/medication(s):_____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No , If yes, how long should patient wait before starting the new medication? _____
- If applicable, indicate if patient hs received starter/titration does of requested agent ☐ Yes ☐ No
- Has patient received a PPD (tuberculosis) Skin Test? ☐ Yes ☐ No Results:

Prior to initiating treatment and periodically durning therapy, patient should be evaluated for

PRESCRIPTION INFORMATION

☐ All supplies including Syringes and needles will be dispensed if needed.

# of Prescriptions Prescribed: _____

☐ **Erivedge 150mg Capsule** ☐ **Enroll in Everidge Cares Program**

☐ Take 1 capsule (150 mg) take orally once daily until disease progression or until unacceptable toxicity — Qty: _____ Refills: _____

☐ **Humira® Pen 40 mg/0.8mL OR ☐ Humira® Pre-Filled Syringe 40 mg/0.8mL** *(Pen will be dispensed if not checked)* ☐ **Enroll in myHumira® Program**

☐ Starting Dose for Hidradenitis Suppurativa: **Day 1**: 160 mg SubQ (Four 40 mg injections); **Day 15**: 80 mg SubQ (two 40mg injections) — Qty:_____ Refills: _____

☐ Maintenance Dose for Hidradenitis Suppurativa: Day 29 +: 40 mg SubQ once every other week — Qty: _____ Refills: _____

☐ Other _____ — Qty: _____ Refills: _____

☐ **Humira® Pen Psoriasis Starter Kit (4 x 40 mg/0.8ml pens) OR ☐ Humira® Pre-Filled Syringe 40 mg/0.8mL** *(Pen Starter Kit will be dispensed if not checked)* ☐ **Enroll in myHumira® Program**

☐ Starting Dose for Psoriasis: **Day 1**: 80 mg Sub Q (Two 40 mg injections); **Day 8+**: 40 mg SubQ once every other week — Qty: _____ Refills: _____

☐ Maintenance Dose: 40 mg SubQ once every other week — Qty: _____ Refills: _____

☐ Other _____ — Qty: _____ Refills: _____

☐ **Enbrel® 50 mg/mL SureClick (autoinjector) OR ☐ Enbrel® 50mgPFS (pre-filled syringes)** *(SureClick will be dispensed if not preference indiciated)* ☐ **Enroll in Enliven® Program**

☐ Starting Dose: 50 mg SQ Twice weekly (72-96 hours apart) — Qty: _____ Refills: _____

☐ Maintenance Dose: 50 mg SQ weekly ☐ Other _____ — Qty: _____ Refills: _____

☐ **Enbrel® 25mg/0.5ml PFS OR ☐ 25 mg Mulitple-Use Vial** *(Pre-filled Syringe will be dispensed if no preference indicated)* ☐ **Enroll in Enliven® Program**

☐ 25 mg SQ Twice Weekly (72-96 hours apart) ☐ Other _____ — Qty: _____ Refills: _____

☐ **Simponi® 50 mg/0.5ml ☐ SmartJect (prefilled autoinjector) OR ☐ PFS (pre-filled syringe)** *(Pen will be dispensed if no preference indicated)* ☐ **Enroll in SimponiOne® Program**

☐ 50 mg SQ every month ☐ Other _____ — Qty: _____ Refills: _____

☐ **Otezla® tablets**

☐ Titration Dose: **Day 1**: 10 mg in morning; **Day 2**: 10 mg in morning and 10 mg in evening; **Day 3**: 10 mg in morning and 20 mg in evening; **Day 4**: 20 mg in moning an 20 mg in evening; **Day 5**; 20 mg in morning an 30 mg in evening; **Day 6** and thereafter; 30 mg twice daily — Qty: _____ Refills: _____

☐ Maintenance Dose: 30 mg twice daily ☐ Other _____ — Qty: _____ Refills: _____

☐ **Stelara™ PSF (Pre-Filled Syringe) OR ☐ Stelara™ vial** ☐ **Enroll in myHumira® Program**

≤ 100kg ☐ Starting Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 weeks of initial dose (week 4) — Qty: _____ Refills: _____

☐ Maintenance Dose: 45 mg SQ every 12 weeks ☐ Other _____ — Qty: _____ Refills: _____

> 100kg ☐ Starting Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 weeks of initial dose (week 4) — Qty: _____ Refills: _____

☐ Maintenance Dose: 90 mg SQ every 12 weeks ☐ Other _____ — Qty: _____ Refills: _____

☐ **Cosentyx™ 150 mg/mL PFS OR ☐ Cosentyx™ 150 mg/ml Sensoready® pen ☐ Cosentyx™ 150 mg vial of lophilized powder** *(Sensoready® pen will be dispensed if no preference indicated)*

☐ Starting Dose: 300 mg SQ initially (weeks 0, 1, 2, 3 and 4), then 300 mg SQ every 4 weeks thereafter (week 4) — Qty: _____ Refills: _____

☐ Maintenance Dose: 300 mg SQ every 4 weeks ☐ Other _____ — Qty: _____ Refills: _____

☐ **Remicade® 100 mg vial**

☐ Clinic infusion ☐ infusion supplies needed (infusion supplies will not be provided unless they are requested) ☐ **Enroll in AccessOneSM Program**

☐ Home Infusion (we will fax you "TruCare Pharmacy Home Infusion Protocol" to be signed by MD)

☐ New Starter: _____mg IV on week 0, week 2 & week 6 then, ☐ Starter doses not needed — Qty: _____ Refills: _____

Maintenance Dose: _____mg IV every _____ weeks — Qty: _____ Refills: _____

☐ **Oxsoralen-Ultra®** _____ **10mg** Other: _____ — Qty: _____ Refills: _____

☐ **Zolinza®** **Sig:** 400mg ONCE daily Other: _____ — Qty: _____ Refills: _____

Physician's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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