JOSEFS PHARMACY

2100 New Bern Ave,
Raleigh, NC 27610
P. 855-326-9112 / F. 855-326-9114

# Dermatology (A-K)

Date: _____ Date needed: _____ Ship to: ☐ Patient ☐ 1st dose to MD ☐ All doses to MD

## Prescriber information

| | |
|---|---|
| Prescriber: | NPI: |
| Supervising physician: | NPI: |
| Address: | |
| Phone: | Fax: |
| Office contact: | |

## Patient information

| | | | |
|---|---|---|---|
| Name: | Sex: ☐ M ☐ F | DOB: | SSN: |
| Address: | City: | State: | Zip: |
| Phone: | Emergency contact: | Phone: | |
| Weight: Height: | Allergies: | | |
| Primary language: ☐ English ☐ Spanish ☐ Other: | Needs interpreter: ☐ Yes ☐ No | | |

***Please include copies of the patient's insurance card or local pharmacy information.***

## Medical information

| | | |
|---|---|---|
| Primary diagnosis: ICD-10: | Date of diagnosis: | |
| Previous therapies: | Duration: | Outcome: |
| | | |
| | | |

## Prescription information

| Drug | Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| ☐ Cimzia® | ☐ 200 mg prefilled syringe | **Initial:** ☐ Inject 400 mg subcutaneously at weeks 0, 2, and 4<br>**Maintenance:** ☐ Inject 200 mg subcutaneously once every 14 days ☐ 400 mg subcutaneously once every 14 days | 1 starter kit<br>4 week supply | 0<br>____ |
| ☐ Cosentyx® | ☐ SensorReady Pen<br>☐ Prefilled syringe | **Initial**: ☐ Inject 150 mg subcutaneously on week 0, 1, 2, 3, and 4<br>**Maintenance:** ☐ Inject 150 mg subcutaneously every 4 weeks<br>**Initial**: ☐ Inject 300 mg subcutaneously on week 0, 1, 2, 3, and 4<br>**Maintenance:** ☐ Inject 300 mg subcutaneously every 4 weeks | 5<br>1<br>10<br>2 | 0<br>____<br>0<br>____ |
| ☐ Dupixent® | ☐ 300 mg/2 ml Syringe | **Initial:** ☐ Inject 600 mg subcutaneously on day 1, then starting day 15 inject 300 mg subcutaneously every other week<br>**Maintenance:** ☐ Inject 300 mg subcutaneously every other week | 2<br>2 | 1<br>____ |
| ☐ Enbrel® | ☐ 25 mg prefilled syringe<br>☐ 50 mg prefilled syringe<br>☐ 50 mg SureClick™<br>☐ 50 mg Mini® | **Initial:** ☐ Inject 50 mg subcutaneously twice a week 72 to 96 hours apart<br>**Maintenance:** ☐ Inject 25 mg subcutaneously once weekly<br>**Maintenance:** ☐ Inject 50 mg subcutaneously once weekly | 4 week supply | ____<br>____<br>____ |
| ☐ Humira® (Psoriasis) | ☐ 40 mg/0.8 ml PFS<br>☐ 40 mg/0.8ml PENS<br>☐ 40 mg/0.4 ml CF PEN | **Initial:** ☐ Inject 80 mg subcutaneously on day 1, then 40 mg on day 8, then 40 mg every other week starting day 22<br>**Maintenance:** ☐ Inject 40 mg subcutaneously every other week | 4<br>2 | 0<br>____ |
| ☐ Humira® (Hidradenitis Suppurativa) | ☐ 40 mg/0.8 ml PFS<br>☐ 40 mg/0.8ml PEN<br>☐ 40 mg/0.4 ml CF PEN | **Initial:** ☐ Inject 160 mg subcutaneously on day 1, then 80 mg on day 15, then 40 mg every week starting day 29<br>**Maintenance:** ☐ Inject 40 mg subcutaneously every week | 6<br>4 | 0<br>____ |
| ☐ Ilumya™ | ☐ 100 mg prefilled syringe | **Initial:** ☐ Inject 100 mg subcutaneously at week 0 and week 4<br>**Maintenance:** ☐ Inject 100 mg subcutaneously every 12 weeks | 1<br>1 | 1<br>____ |
| ☐ Other | _____ | _____ | | |
| ☐ Prescriber authorizes dispensing of ancillary kits and supplies as necessary/applicable | | As needed for administration | | |

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

***Stamp signature not allowed, physician attests this is his/her legal signature.***

PHYSICIAN SIGNATURE REQUIRED

_____ **Dispense as Written / Brand Medically Necessary**

_____ **Substitution allowed**