



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

Dermatology (L-Z)

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

Prescriber information	
Prescriber:	NPI:
Supervising physician:	NPI:
Address:	
Phone:	Fax:
Office contact:	

Patient information			
Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight:	Height:	Allergies:	
Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		Needs interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter pack <input type="checkbox"/> 30 mg tablets	<input type="checkbox"/> Starter pack: Take as directed per package instructions <input type="checkbox"/> Maintenance: Take one tablet by mouth once daily <input type="checkbox"/> Maintenance: Take one tablet by mouth twice daily	1 pack 30 60	0 _____ _____
<input type="checkbox"/> Siliq™	210 mg pre-filled syringe	Initial: <input type="checkbox"/> Inject 210 mg subcutaneously on weeks 0, 1, 2, then begin maintenance dose starting week 4 Maintenance: <input type="checkbox"/> Inject 210 mg subcutaneously every two weeks	4 2	0 _____ _____
<input type="checkbox"/> Skyrizi™	Please use form available from the manufacturer's website and send to Josefs Pharmacy			
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45 mg prefilled syringe (Weight < 220 lbs)	Initial: <input type="checkbox"/> Inject 45 mg subcutaneously on day 0, then week 4, then every 12 weeks Maintenance: <input type="checkbox"/> Inject 45 mg subcutaneously every 12 weeks	1 1	2 _____ _____
	<input type="checkbox"/> 90 mg prefilled syringe (Weight ≥ 220 lbs)	Initial: <input type="checkbox"/> Inject 90 mg subcutaneously on day 0, then week 4, then every 12 weeks Maintenance: <input type="checkbox"/> Inject 90 mg subcutaneously every 12 weeks	1 1	2 _____ _____
<input type="checkbox"/> Tremfya™	<input type="checkbox"/> 100 mg/ml prefilled syringe	Initial: <input type="checkbox"/> Inject 100 mg subcutaneously at week 0 and week 4 Maintenance: <input type="checkbox"/> Inject 100 mg subcutaneously every 8 weeks	1 1	1 _____ _____
	<input type="checkbox"/> 100 mg/ml auto injector	Initial: <input type="checkbox"/> Inject 100 mg subcutaneously at week 0 and week 4 Maintenance: <input type="checkbox"/> Inject 100 mg subcutaneously every 8 weeks	1 1	0 _____ _____
<input type="checkbox"/> Taltz® (Psoriasis)	<input type="checkbox"/> 80 mg/ml prefilled syringe	Initial: <input type="checkbox"/> Inject 160 mg subcutaneously at week 0 Induction: <input type="checkbox"/> Inject 80 mg subcutaneously every two weeks (weeks 2, 4, 6, 8, 10, and 12) Maintenance: <input type="checkbox"/> Inject 80 mg subcutaneously every 4 weeks	1 2 1	0 3 _____ _____
	<input type="checkbox"/> 80 mg/ml auto injector	Initial: <input type="checkbox"/> Inject 160 mg subcutaneously at week 0 Induction: <input type="checkbox"/> Inject 80 mg subcutaneously every two weeks (weeks 2, 4, 6, 8, 10, and 12) Maintenance: <input type="checkbox"/> Inject 80 mg subcutaneously every 4 weeks	1 2 1	0 3 _____ _____
<input type="checkbox"/> 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

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