ameripharma SPECIALTY CARE

DERMATOLOGY (A-H)

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: ______ DOB: ______ Sex: ☐ Male ☐ Female SSN: ______ Wt (kg/lbs): ______ Ht (cm/in): ______

Address: ______ Phone: ______ Alternate: ______

Caregiver Name: ______ Relation to Patient: ______ Phone: ______

Insurance Plan: ______ Plan ID: ______ BIN #: ______ PCN #: ______ GRP #: ______

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: ______ DEA: ______ NPI: ______

Address: ______

Phone: ______ Alternate: ______ Fax: ______ Email: ______

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ L40.0 (Psoriasis vulgaris) ☐ L40.8 (Other psoriasis) ☐ L40.9 (Psoriasis, unspecified) ☐ L40.5__ (Psoriatic arthritis) ☐ L73.2 (Hidradenitis Suppurativa) ☐ ______

Diagnosis Date: ______ TB Test: ☐ Yes ☐ No Neg. Test Date: ______ HBV: ☐ Yes ☐ No If yes, currently treated: ☐ Yes ☐ No

BSA affected (%): ______ Affected areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ ______

Prior Therapy ☐ Yes ☐ No ______

Reason for Discontinuation of Therapy ______

Approximate Start Date ______ Approximate End Date ______

Comorbidities: ______

Concomitant Medications: ______

Allergies: ☐ NKDA ☐ Other: ______

Prescription	Directions	Quantity	Form	Refill
☐ **Carac®** (fluorouracil)	☐ Apply once a day to the skin where actinic keratosis lesions appear.	☐ ____ x 30 gm, 0.5%	☐ Cream	
☐ **Cimzia®** (certolizumab) *Psoriatic Arthritis*	☐ Inject 400 mg subq at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 200 mg subq every 2 weeks ☐ Inject 400 mg subq every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	
☐ **Cosentyx®** (secukinumab)	☐ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150 mg/mL	☐ Sensoready® Pen	0
	☐ Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3	☐ 8 x 150 mg/mL	☐ PFS	
	☐ Inject 150 mg subq once weekly at week 4 and every 4 weeks thereafter	☐ 1 x 150 mg/mL	☐ Sensoready® Pen	
	☐ Inject 300 mg subq once weekly at week 4 and every 4 weeks thereafter	☐ 2 x 150 mg/mL	☐ PFS	
☐ **Dupixent®** (dupliumab)	☐ Inject 600 mg (2 injections) subq on day 1	☐ 2 x 300 mg	☐ PFS	0
	☐ Inject 300 mg subq every 2 weeks starting on day 15	☐ 2 x 300 mg	☐ PFS	
☐ **Efudex®** (fluorouracil)	☐ Apply cream or solution twice daily in an amount sufficient to cover the lesions	☐ ____ x 10 mL ☐ ____ x 25 mL ☐ ____ x 40 gm	☐ 2% Solution ☐ 5% Solution ☐ 5% Cream	
☐ **Enbrel®** (etanercept)	☐ Inject 50 mg subq twice a week (72-96 hours apart) for 3 months	☐ 8 x 50 mg/mL	☐ SureClick® Autoinjector ☐ PFS	2
	☐ Inject 50 mg subq every week	☐ 4 x 50 mg/mL	☐ SureClick® Autoinjector ☐ PFS	
☐ **Eucrisa®** (crisaborole)	☐ Apply a thin layer to affected areas twice daily	☐ ____ x 20 mg/gm	☐ 2% Ointment	
☐ **Humira®** (adalimumab)	☐ **Plaque Psoriasis:** Inject 80 mg subq day 1, then 40 mg on day 8, then 40 mg every 2 weeks thereafter ☐ **Hidradenitis Suppurativa:** Inject 160 mg subq onday 1, then 80 mg on day 15 ☐ ______	☐ 4 x 40 mg/0.8mL ☐ 6 x 40 mg/0.8mL	☐ Pens ☐ PFS	0
	☐ **Plaque Psoriasis:** Inject 40 mg subq every 2 weeks ☐ **Hidradenitis Suppurativa:** Inject 40 mg subq on day 29 and every week thereafter	☐ 2 x 40 mg/0.8mL ☐ 4 x 40 mg/0.8mL	☐ Pens ☐ PFS	

Injection training provided by: ☐ Physician's Office ☐ Pharmacy ☐ Other:

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:

Prescriber's Signature: ______ Date: ______

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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