ameripharma SPECIALTY CARE

DERMATOLOGY (I-Z)

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
☐ **Inflectra®** (infliximab)	☐ Infuse 5 mg/kg at weeks 0 and 2 ☐ Infuse 5 mg/kg at week 6 and then every 8 weeks thereafter	☐ 100 mg	☐ Vials	0
☐ **Otezla®** (apremilast)	☐ Take as directed per package instructions ☐ Prescriber provided patient with 2 week starter pack sample on date _____	☐ 55 tablets	☐ 28-day starter pack	0
	☐ Take 30 mg twice daily by mouth ☐ _____	☐ 60 x 30 mg tablets ☐ _____		
☐ **Picato®** (ingenol mebutate)	☐ Apply 1 tube per day for 3 consecutive days ☐ Apply 1 tube per day for 2 consecutive days	☐ ____x 0.015% (face/scalp tx) ☐ ____x 0.05% (body tx)	☐ Gel	
☐ **Remicade®** (infliximab)	☐ Infuse 5 mg/kg intravenously at weeks 0 and 2 ☐ Infuse 5 mg/kg at week 6 and then every 8 weeks thereafter	☐ 100 mg	☐ Vials	0
☐ **Simponi®** (golimumab) *Psoriatic Arthritis*	☐ Inject 50 mg subq once a month	☐ 1 x 50 mg/0.5mL	☐ SmartJect® Autoinjector ☐ PFS	
☐ **Sivextro®** (tedizolid phosphate)	☐ Inject 200 mg IV once daily for 6 days ☐ Take 1 tablet by mouth daily for 6 days	☐ 6 x 200mg	☐ IV ☐ Tablet	
☐ **Stelara®** (ustekinumab)	☐ Inject 45 mg subq on Day 1 (≤100 kg) ☐ Inject 90 mg subq on Day 1 (>100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 x 90 mg/mL	☐ PFS	0
	☐ Inject 45 mg subq on Day 29 and every 12 weeks thereafter (≤100 kg) ☐ Inject 90 mg subq on Day 29 and every 12 weeks thereafter (>100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 x 90 mg/mL	☐ PFS	
	Patient eligible for self-administration: ☐ Yes ☐ No			
☐ **Taltz®** (Ixekizumab)	☐ Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subq at week 0, then inject 80 mg subq at week 2	☐ 3 x 80 mg/mL	☐ Autoinjectors ☐ PFS	0
	☐ Weeks 4 - 10: Inject 80 mg subq at week 4 and every two weeks thereafter through week 10	☐ 2 x 80 mg/mL	☐ Autoinjectors ☐ PFS	1
	☐ Week 12 onwards: Inject 80 mg subq at week 12 and every four weeks thereafter	☐ 1 x 80 mg/mL	☐ Autoinjectors ☐ PFS	
☐ **Tremfya®** (guselkumab)	☐ Inject 100 mg subq at weeks 0 and 4	☐ 2 x 100 mg	☐ PFS	0
	☐ Inject 100 mg subq every 8 weeks	☐ 1 x 100 mg		
☐ **Zyvox®** (linezolid)	☐ Inject 600 mg IV twice a day ☐ Take 1 tablet by mouth twice daily	☐ _____ x 600 mg	☐ IV ☐ Tablets	

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.

Reset Form