Dermatology (I-Z)

Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, ZIP: _____
Home Phone: _____ Alternate Phone: _____
Caregiver: _____ Email: _____
DOB: _____ Social Security#: _____
Gender: ☐ Male ☐ Female Comorbidities: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____ Fax: _____
NPI: _____ Tax ID: _____
DEA: _____
Office Contact: _____ Phone: _____
Contact Email: _____

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION [Please fax all pertinent clinical and lab information and/or attach separate sheet if needed.]

Diagnosis and IDC-10 Code: _____

Prior Therapy ☐ Yes ☐ No	Approx. Therapy Start/End Dates	Reason for Discontinuation of Therapy	Prior History
☐ Cimzia®	_____ to _____		☐ 5-ASA
☐ Enbrel®	_____ to _____		☐ Immunosuppressants (6-MP/other)
☐ Humira®	_____ to _____		☐ Corticosteroids
☐ Remicade®	_____ to _____		☐ Methotrexate
☐ Simponi®	_____ to _____		☐ Surgery
☐ Stelara®	_____ to _____		☐ Other: _____
☐ Other: _____	_____ to _____		☐ Other: _____

Date of Diagnosis: _____
TB test?: ☐ Yes ☐ No Negative TestDate: _____
BSA %: _____
Concomitant Medications: _____
Additional Information: _____

PRESCRIPTION INFORMATION

Medication	Directions	Quantity		Refills
☐ Otezla®	☐ **Day 1:** 10 mg AM **Day 2:** 10 mg AM, 10 mg PM **Day 3:** 10mg AM, 20 mg PM **Day 4:** 20mg AM, 20 mg PM **Day 5:** 20mg AM, 30 mg PM **Day 6 and thereafter:** 30mg twice daily (as indicated on starter package)	☐ One 4 Week Starter Pack		
	☐ 30 mg twice daily ☐ Other: _____	☐ 1 carton of 28-count 30 mg tablets *(2 blister packs containing 14 tablets each)* ☐ 60 tablets		
☐ Simponi®	☐ Inject 1 dose (50 mg) Sub-Q once monthly	☐ One 50 mg/0.5 mL	☐ PFS ☐ SmartJect®	
☐ Stelara®	☐ Inject 1 PFS Sub-Q on Day 1	☐ 45 mg/0.5 mL [<100 kg] ☐ 90 mg/mL [>100 kg]	☐ PFS	
	☐ Inject 1 PFS Sub-Q starting on day 29 & every 12 weeks thereafter	☐ 45 mg/0.5 mL [<100 kg] ☐ 90 mg/mL [>100 kg]	☐ PFS	
☐ Taltz® (Ixekizumab)	☐ Weeks 0 - 2: Inject 160 mg (2 x 80 mg) sub-Q at week 0, then inject 80 mg Sub-Q at week 2	☐ 3 x 80 mg/mL	☐ PFS ☐ Autoinjectors	
	☐ Weeks 4 - 10: Inject 80 mg Sub-Q at week 4 and every two weeks thereafter through week 10	☐ 2 x 80 mg/mL	☐ PFS ☐ Autoinjectors	
	☐ Week 12 onwards: Inject 80 mg sub-Q at week 12 and every four weeks thereafter	☐ 1 x 80 mg/mL	☐ PFS ☐ Autoinjectors	

☐ Other Medication: _____ Dose: _____ Quantity: _____ Refills: _____
Direction(s): _____

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: _____ Needs by Date: _____

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____
PRODUCT SUBSTITUTION PERMITTED ***Dispense As Written***

CONFIDENTIALITY NOTICE