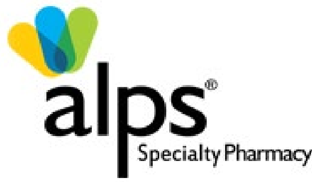

Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

Dermatology (A-H)

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
☐ Cimzia®	☐ 400 mg Sub-Q at weeks 0, 2 and 4	☐ 1 Starter Kit = 2x200 mg/mL	☐ PFS ☐ Lyophilized Vials	
	☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 Starter Kit = 6x200 mg/mL ☐ 3 cartons = 6x200 mg	☐ PFS ☐ Lyophilized Vials	
☐ Cosentyx®	☐ Inject 150 mg Sub-Q once weekly at weeks 0, 1, 2 and 3 ☐ Inject 300 mg Sub-Q once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150 mg/mL ☐ 8 X 150 mg/mL	☐ PFS ☐ Sensoready® Pen	
	☐ Inject 150 mg Sub-Q on day 29 and every 4 weeks thereafter ☐ Inject 300 mg Sub-Q on day 29 and every 4 weeks thereafter	☐ 1 x 150 mg/mL ☐ 2 x 150 mg/mL	☐ PFS ☐ Sensoready® Pen	
☐ Dupixent®	☐ Inject 600 mg (2 syringes) Sub-Q on day 1, followed by 300 mg every other week	☐ 2 x 300mg (14 day supply)	☐ PFS	
	☐ Inject 300 mg Sub-Q every other week	☐ 2 x 300mg	☐ PFS	
☐ Enbrel®	☐ Inject 50 mg Sub-Q once a week ☐ Other: ______	☐ 1 carton = 4 x 50 mg/mL ☐ 1 carton = 4 x 25 mg/mL ☐ Other: ______	☐ PFS ☐ SureClick® ☐ Vial	
☐ Humira® (adalimumab)	☐ Inject 80 mg (2 pens) Sub-Q on day 1, then 40 mg (1 pen) on day 8, then 40 mg every other week thereafter	☐ 1 Psoriasis Starter Kit = 4 x 40 mg/0.8 mL device	☐ Starter Kit	
	☐ Inject 40 mg Sub-Q every other week ☐ Other: ______	☐ 1 Carton = 2 x 40 mg/0.8mL ☐ Other: ______	☐ Pen ☐ PFS	
☐ Humira® Citrate-Free (adalimumab)	☐ Inject 80 mg (1 80 mg pen) Sub-Q on day 1, then 40 mg (1 40 mg pen) on day 8, then 40 mg (1 40 mg pen) every other week thereafter	☐ 1 Psoriasis Starter Kit = (1 x 80 mg/0.8 mL device, 2 x 40 mg/0.4 mL device)	☐ Starter Kit	
	☐ Inject 40 mg Sub-Q every other week ☐ Other: ______	☐ 1 Carton = 2 x 40 mg/0.4mL ☐ Other: ______	☐ Pen ☐ PFS	

☐ 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: ______
PRODUCT SUBSTITUTION PERMITTED

Prescriber's Signature: ______ Date: ______
Dispense As Written

CONFIDENTIALITY NOTICE

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