URAC ACCREDITED
Specialty Pharmacy
Expires 07/01/2021

ACHC ACCREDITED

FountainRx

2825 W. A.J. Hwy. Morristown, TN 37814
**Phone: 423-307-5757**
**Toll Free: 844-990-9993**
Please fax supporting documentation with Rx to:
**423-307-5241**

# Dermatology

**Patient Information:**

Name:_____
Address:_____
City:_____State:____Zip:_____
Phone:_____Alt Phone:_____
Email:_____Soc. Sec. #_____
DOB:_____Height:_____Weight:_____
Gender: M F Caregiver:_____

**Prescriber Information:**

Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____
NPI:_____DEA:_____
Tax ID:_____
Office Contact:_____Phone:_____

**CLINICAL INFORMATION:** **Diagnosis Date:**_____ ☐ **L40.0 Moderate to Severe Plaque Psoriasis** ☐ **L40.50 Arthropathic psoriasis, unspecified**
☐ **L73.2 Hidradenitis Suppurativa—Hurley Stage:**_____ ☐ **L20.9 Atopic Dermatitis unspecified** ☐ **Other:**_____

**Drug Allergies:** _____

**Latex Allergy?** **Yes** **No** **TB/PPD Test given?** **Yes** **No** **Has Hepatitis B been ruled out?** **Yes** **No**

**Prior Failed Medications:** ☐ _____Length of Treatment:_____Reason for Discontinuing:_____
☐ _____Length of Treatment:_____Reason for Discontinuing:_____

**PLEASE FAX COPIES:** ☐ **Medical Card (Front and Back)** ☐ **Prescription Card (Front and Back)** ☐ **Clinical Notes**

| Medication | Dosage and Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ **Cosentyx®** | ☐ 150mg/ml Sensoready® Pen<br>☐ 150mg/ml Prefilled Syringe<br>☐ 150mg/ml Lyophilized Powder Vial | ☐ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4<br>☐ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4<br>☐ **Maintenance Dose:** Inject 150mg SC every four (4) weeks<br>☐ **Maintenance Dose:** Inject 300mg SC every four (4) weeks | 5<br>10<br>1<br>2 | None<br>None<br><br>_____ |
| ☐ **Dupixent®** | ☐ 300mg/2ml - Syringe 2 Pack | **Initial Dose**: Inject 600mg SC at day 1<br>**Maintenance Dose:** 300mg SC every other week starting on day 15 | 2<br>2 | None<br>_____ |
| ☐ **Enbrel®** | ☐ 50mg/ml SureClick® Autoinjector<br>☐ 50mg/ml Enbrel Mini™ Prefilled Cartridge<br>☐ 50mg/ml Prefilled Syringe<br>☐ 25mg/0.5ml Prefilled Syringe<br>☐ 25mg/ml Vial | ☐ Inject 25mg SC twice a week 72-96 hours apart<br>☐ Inject 50mg SC once a week<br>☐ Inject 50mg SC twice a week 72-96 hours apart | 8<br>4<br>8 | <br><br>_____ |
| ☐ **Eucrisa®** | 2% Ointment - 60gm tube | Apply a thin film to affected area(s) two times a day | 60 grams | |
| ☐ **Humira®** | ☐ Psoriasis Starter Kit<br>☐ 40mg/0.8ml Pen<br>☐ 40mg/0.8ml Prefilled Syringe<br>☐ 40mg/0.4ml Pen<br>☐ 40mg/0.4ml Prefilled Syringe | ☐ **Psoriasis Starter Kit:** Inject two 40mg (80mg) SC on day 1, then 40mg on day 8, then 40mg every other week<br>☐ **Maintenance Dose:** Inject 40mg SC every other week<br>☐ **Maintenance Dose:** Inject 40mg SC once a week<br>☐ Pt. has signed Humira Complete form<br>☐ Other: _____ | 4<br><br>2<br>4<br><br>_____ | None<br><br><br><br><br>_____ |
| ☐ **Orencia®** | ☐ 125mg/ml ClickJect™ Autoinjector<br>☐ 50mg/0.4ml Prefilled Syringe<br>☐ 87.5mg/0.7ml Prefilled Syringe<br>☐ 125mg/ml Prefilled Syringe<br>☐ 250mg Lyophilized Powder Vial | ☐ **Induction Dose:** Patient Weight < 132lbs - 500mg; 132-220lbs - 750mg; > 220lbs 1000mg administered IV, then inject 125mg SC within 24 hours<br>☐ **Maintenance Dose:** Inject 50mg SC once a week (22lbs to less than 55lbs)<br>☐ **Maintenance Dose:** Inject 87.5mg SC once a week (55lbs to less than 110lbs)<br>☐ **Maintenance Dose:** Inject 125mg SC once a week (110lbs or more) | _____<br>4<br>4<br>4 | None<br><br><br>_____ |
| ☐ **Otezla®** | ☐ Starter Pack (Titration)<br>☐ 30mg Tablets | ☐ **Starter Pack:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack<br>☐ **Maintenance Dose:** Take one 30mg tablet by mouth twice daily | 55<br>60 | None<br>_____ |
| ☐ **Siliq™** | ☐ 210mg Prefilled Syringe | ☐ **Initial Dose:** Inject 210mg SC on weeks 0 and 1<br>☐ **Maintenance Dose:** Inject 210 SC every 2 weeks starting at week 2 | 2<br>2 | <br>_____ |
| ☐ **Simponi®** | ☐ 50mg/0.5ml Smartject Autoinjector<br>☐ 50mg/0.5ml Prefilled Syringe<br>☐ Aria: 50mg/4ml vial | ☐ Inject 50mg once a month<br>☐ Infuse _____ mg at weeks 0 and 4 then every 8 weeks thereafter | 1<br>_____ | <br>_____ |
| ☐ **Stelara®** | ☐ 45mg/0.5ml Prefilled Syringe (for <220lbs)<br>☐ 90mg/1ml Prefilled Syringe (for >220lbs) | ☐ **Initial Dose:** Inject one (1) prefilled syringe SC at 0 and 4 weeks<br>☐ **Maintenance Dose:** Inject one (1) prefilled syringe SC every 12 weeks | 2<br>1 | <br>_____ |
| ☐ **Taltz®** | ☐ 80mg/ml Prefilled Autoinjector<br>☐ 80mg/ml Prefilled Syringe | ☐ **Initial Dose:** Inject 160mg SC at week 0<br>☐ **Maintenance Dose:** Inject 80mg at weeks 2, 4, 6, 8,10, and 12 then 80mg every 4 weeks<br>☐ **Maintenance Dose:** Inject 80mg every 4 weeks | 2<br>2<br>1 | <br><br>_____ |
| ☐ **Tremfya™** | ☐ 100mg Prefilled Syringe | ☐ **Initial Dose:** Inject 100mg SC at week 0 then at week 4<br>☐ **Maintenance Dose:** Inject 100mg SC every 8 weeks | 2<br>1 | <br>_____ |

*By signing this form and utilizing our services, you are authorizing Fountain Plaza Pharmacy, LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.*

**Physician Signature:**_____ **Date:**_____