



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 Results?** Positive Negative **Body Surface Area (BSA):** _____

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
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150mg/ml Sensoready® Pen	<input type="checkbox"/> Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	None
	<input type="checkbox"/> 150mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	None
		<input type="checkbox"/> Maintenance Dose: Inject 150mg SC every four (4) weeks	1	
		<input type="checkbox"/> Maintenance Dose: Inject 300mg SC every four (4) weeks	2	
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300mg/2ml - Syringe 2 Pack	<input type="checkbox"/> Initial Dose: Inject 600mg SC at day 1	2	None
	<input type="checkbox"/> 200mg/1.14ml - Syringe 2 Pack	<input type="checkbox"/> Initial Dose: Inject 400mg SC at day 1	2	None
		<input type="checkbox"/> Maintenance Dose: 300mg SC every other week starting on day 15	2	
		<input type="checkbox"/> Maintenance Dose: 200mg SC every other week starting on day 15	2	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml SureClick® Autoinjector	<input type="checkbox"/> Inject 25mg SC twice a week 72-96 hours apart	8	
	<input type="checkbox"/> 50mg/ml Enbrel Mini™ Prefilled Cartridge	<input type="checkbox"/> Inject 50mg SC once a week	4	
	<input type="checkbox"/> 50mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC twice a week 72-96 hours apart	8	
	<input type="checkbox"/> 25mg/0.5ml Prefilled Syringe			
<input type="checkbox"/> Humira®	<input type="checkbox"/> Psoriasis Starter Kit CF	<input type="checkbox"/> Psoriasis Starter Kit: Inject 80mg SC day 1, then 40mg on day 8, then 40mg every other week	3	None
	<input type="checkbox"/> Hidradenitis Suppurativa Starter Kit CF	<input type="checkbox"/> H. Suppurativa Starter Kit: Inject 160mg (2-syringes) SC on day 1, then 80mg on day 15	3	None
	<input type="checkbox"/> 40mg/0.4ml Pen CF	<input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week	2	
	<input type="checkbox"/> 40mg/0.4ml Prefilled Syringe CF	<input type="checkbox"/> Maintenance Dose: Inject 40mg SC once a week	4	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector	<input type="checkbox"/> Maintenance Dose: Inject 125mg SC once a week (110lbs or more)	4	
	<input type="checkbox"/> 125mg/ml Prefilled Syringe			
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Pack (Titration)	<input type="checkbox"/> 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	55	None
	<input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Maintenance Dose: Take one 30mg tablet by mouth twice daily	60	
<input type="checkbox"/> Skyrizi™	<input type="checkbox"/> 75mg/0.83ml Prefilled Syringe (2 pack)	<input type="checkbox"/> Initial Dose: Inject 150mg SC at weeks 0 and 4	2	None
		<input type="checkbox"/> Maintenance Dose: Inject 150mg SC every 12 weeks	1	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector	<input type="checkbox"/> Inject 50mg once a month	1	
	<input type="checkbox"/> 50mg/0.5ml Prefilled Syringe			
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for <220lbs)	<input type="checkbox"/> Initial Dose: Inject one (1) prefilled syringe SC at 0 and 4 weeks	2	None
	<input type="checkbox"/> 90mg/1ml Prefilled Syringe (for >220lbs)	<input type="checkbox"/> Maintenance Dose: Inject one (1) prefilled syringe SC every 12 weeks	1	
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80mg/ml Prefilled Autoinjector	<input type="checkbox"/> Initial Dose: Inject 160mg SC at week 0 and 80mg at week 2	3	None
	<input type="checkbox"/> 80mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 80mg at weeks 2, 4, 6, 8, 10, and 12 then 80mg every 4 weeks	5	
		<input type="checkbox"/> Initial Dose: Inject 160mg SC at week 0	2	None
		<input type="checkbox"/> Maintenance Dose: Inject 80mg every 4 weeks	1	
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> 100mg Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 100mg SC at week 0 then at week 4	2	None
	<input type="checkbox"/> 100mg One-Press Injector	<input type="checkbox"/> Maintenance Dose: Inject 100mg SC every 8 weeks	1	
<input type="checkbox"/> Other				

By signing this form and utilizing our services, you are authorizing FountainRx 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:** _____