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Phone: 423-307-5757
6900 Lenox Village Dr., Ste #14 Nashville, TN 37211
Phone: 615-864-8990

FountainRx

Dermatology

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

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
☐ **Cosentyx®**	☐ 150mg/ml Sensoready® Pen ☐ 150mg/ml Prefilled Syringe	☐ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4 ☐ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject 150mg SC every four (4) weeks ☐ **Maintenance Dose:** Inject 300mg SC every four (4) weeks	5 10 1 2	None None
☐ **Dupixent®**	☐ 300mg/2ml - Syringe 2 Pack ☐ 200mg/1.14ml - Syringe 2 Pack ☐ 300mg/2ml - Pen 2 Pack ☐ 200mg/1.14 ml - Pen 2 Pack	☐ **Initial Dose**: Inject 600mg SC at day 1 ☐ **Initial Dose:** Inject 400mg SC at day 1 ☐ **Maintenance Dose:** 300mg SC every other week starting on day 15 ☐ **Maintenance Dose:** 200mg SC every other week starting on day 15	2 2 2 2	None None
☐ **Enbrel®**	☐ 50mg/ml SureClick® Autoinjector ☐ 50mg/ml Enbrel Mini™ Prefilled Cartridge ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg/ml Vial	☐ Inject 25mg SC twice a week 72-96 hours apart ☐ Inject 50mg SC once a week ☐ Inject 50mg SC twice a week 72-96 hours apart	8 4 8	
☐ **Humira®**	☐ Psoriasis Starter Kit CF ☐ Hidradenitis Suppurativa Starter Kit CF ☐ 40mg/0.4ml Pen CF ☐ 40mg/0.4ml Prefilled Syringe CF ☐ 80mg/0.8ml Pen CF	☐ **Psoriasis Starter Kit:** Inject 80mg SC day 1, then 40mg day 8, then 40mg every other week ☐ **H. Suppurativa Starter Kit:** Inject 160mg (2-syringes) SC on day 1, then 80mg on day 15 ☐ **Maintenance Dose:** Inject 40mg SC every other week ☐ **Maintenance Dose:** Inject 40mg SC once a week ☐ **Maintenance Dose:** Inject 80mg SC every other week	3 3 2 4 2	None None
☐ **Orencia®**	☐ 125mg/ml ClickJect™ Autoinjector ☐ 125mg/ml Prefilled Syringe	☐ **Maintenance Dose:** Inject 125mg SC once a week (110lbs or more)	4	
☐ **Otezla®**	☐ Starter Pack (Titration) ☐ 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 ☐ **Maintenance Dose:** Take one 30mg tablet by mouth twice daily	55 60	None
☐ **Skyrizi™**	☐ 150mg/ml Prefilled Pen ☐ 150mg/ml Prefilled Syringe	☐ **Initial Dose:** Inject 150mg SC at weeks 0 and 4 ☐ **Maintenance Dose:** Inject 150mg SC every 12 weeks	2 1	None
☐ **Simponi®**	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg once a month	1	
☐ **Stelara®**	☐ 45mg/0.5ml Prefilled Syringe (for <220lbs) ☐ 90mg/1ml Prefilled Syringe (for >220lbs)	☐ **Initial Dose:** Inject one (1) prefilled syringe SC at 0 and 4 weeks ☐ **Maintenance Dose:** Inject one (1) prefilled syringe SC every 12 weeks	2 1	None
☐ **Taltz®**	☐ 80mg/ml Prefilled Autoinjector ☐ 80mg/ml Prefilled Syringe	☐ **Initial Dose:** Inject 160mg SC at week 0 and 80mg at week 2 ☐ **Maintenance Dose:** Inject 80mg at weeks 4, 6, 8,10, and 12 then 80mg every 4 weeks ☐ **Initial Dose:** Inject 160mg SC at week 0 ☐ **Maintenance Dose:** Inject 80mg every 4 weeks	3 5 2 1	None None
☐ **Tremfya®**	☐ 100mg Prefilled Syringe ☐ 100mg One-Press Injector	☐ **Initial Dose:** Inject 100mg SC at week 0 then at week 4 ☐ **Maintenance Dose:** Inject 100mg SC every 8 weeks	2 1	None
☐ **Other**				

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