For assistance, contact your pharmacy representative: ______________________ Phone: ______________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens + PRIME

Dermatology

Prescription/Pharmacy Intake Form

Pharmacy: ______________________

Pharmacy Fax: ______________________ Pharmacy Phone: ______________________

Date Needed: __________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ______________________

PATIENT INFORMATION

Patient name: ______________________ DOB: __________ ☐Male ☐Female

Address: ______________________ City: __________ State: _____ Zip code: __________

Phone # (Daytime): ______________________ Phone # (Evening): ______________________

E-mail Address: ______________________

Insurance provider **(Please include copy of front and back of card)**: ______________________

ID #: __________ Policy/Group #: __________ Phone #: __________ ☐Patient is eligible for Medicare

Name of Insured: ______________________ Employer: ______________________

Relationship to Patient: ☐Self ☐Other: __________ Prescription Card: ☐Yes ☐No Carrier: __________ Policy/Group #: __________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy Start date: __________

Primary Diagnosis Code and Condition (ICD-10): ______________________ Date of Diagnosis/Years with Disease: __________

_____ % BSA affected by Psoriasis Severity: ☐Moderate ☐Moderate to Severe ☐Severe Number of tender/swollen joints: _____ TB Test Result: __________ Date: _______

☐Inadequate Response to Standard Systemic Agents ☐Inadequate Response to Standard Phototherapy Current Weight: _______ Date: _______

Allergies: ______________________

MEDICATIONS

Cimzia (certolizumab pegol)
☐Starter Kit 6x200mg Prefilled Syringes
Qty: _____ Refills: _____
Directions: ______________________
☐2x200mg Vials
☐2x200mg Prefilled Syringes
Qty: _____ Refills: _____
Directions: ______________________

Cosentyx (secukinumab)
☐150mg Pen
☐150mg Prefilled Syringe
☐2X150mg Pack (300mg) Pen
☐2X150mg Pack (300mg) Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Dupixent (dupilumab)
☐200mg Prefilled Syringe with Needle Shield
☐300mg Prefilled Syringe with Needle Shield
Qty: _____ Refills: _____
Directions: ______________________

Enbrel (entanercept)
☐25mg Prefilled Syringe
☐25mg Vial
☐50mg Prefilled Syringe
☐50mg SureClick™ Pen
☐50mg Mini™ Cartridge
Qty: _____ Refills: _____
Directions: ______________________

Humira (adalimumab)
☐4x40mg Pens – Psoriasis Starter Kit
☐6x40mg Pens – Hidradenitis Suppurativa Starter Kit
Qty: _____ Refills: _____
Directions: ______________________
☐40mg/0.8ml Prefilled Syringes
☐40mg/0.8ml Pens
☐Other: ______________________
Qty: _____ Refills: _____
Directions: ______________________

☐**Other:** ______________________
Qty: _____ Refills: _____
Directions: ______________________

Humira citrate free (adalimumab)
☐80mg/0.8ml & 40mg/0.4ml Psoriasis citrate free Starter Kit
☐80mg/0.8ml – Hidradenitis suppurativa citrate free Starter Kit
Qty: _____ Refills: _____
Directions: ______________________
☐40mg/0.4ml citrate free Prefilled Syringes
☐40mg/0.4ml citrate free Pens
☐80mg/0.8ml citrate free Pens
Qty: _____ Refills: _____
Directions: ______________________

Ilumya (tildrakizumab-asmn)
☐100mg/ml Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Inflectra (infliximab-dyyb)
☐100mg Vial
Qty: _____ Refills: _____
Directions: ______________________

Orencia (abatacept)
☐250mg Vial
☐125mg Prefilled Syringe
☐125mg Clickjet Pen
Qty: _____ Refills: _____
Directions: ______________________

Otezla (apremilast)
☐Titration Pack
Qty: _____ Refills: _____
Directions: ______________________
☐30mg Tablets
Qty: _____ Refills: _____
Directions: ______________________

Remicade (infliximab)
☐100mg Vial
Qty: _____ Refills: _____
Directions: ______________________

Renflexis (infliximab-abda)
☐100mg vial
Qty: _____ Refills: _____
Directions: ______________________

Siliq (brodalumab)
☐210mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Simponi (golimumab)
☐50mg SmartJect™ AutoInjector
☐50mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Simponi Aria (golimumab)
☐50mg Vial
Qty: _____ Refills: _____
Directions: ______________________

Skyrizi
☐150mg Prefilled Pen
☐150mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Stelara (ustekinumab)
☐45mg Prefilled Syringe
☐45mg Single-dose Vial
☐90mg Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Taltz (ixekizumab)
☐80mg Prefilled Syringe
☐80mg AutoInjector
Qty: _____ Refills: _____
Directions: ______________________

Tremfya (guselkumab)
☐100mg/ml One-Press Patient-Controlled Injector
☐100mg/ml Prefilled Syringe
Qty: _____ Refills: _____
Directions: ______________________

Xeljanz
☐5mg tablets
☐11mg XR tablets
Qty: _____ Refills: _____
Directions: ______________________

Methotrexate – Can only be ordered with other specialty meds. ☐2.5mg Tablet Directions: ______________________ Qty: _____ Refills: _______

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________

Address: ______________________ City: __________ State: _____ Zip code: __________

Office contact: ______________________ Phone: __________ Fax: __________

Email: ______________________ Best time to call: __________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: __________ DEA #: __________ NPI #: __________ Medicaid UPIN #: __________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

______________________ Dispense as written

______________________ Substitution permitted

__________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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Drug names are the property of their respective owners.

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