CIENEGA PHARMACY Dermatology Prescription Form

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cienegapharmacy.com

DATE:_____NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ 696.1 Psoriasis Moderate to Severe Plaque ❑ 696.0 Psoriatic Arthritis ❑ Other: Dx code_____Condition _____

Location: % BSA:_____❑ Hands ❑ Feet ❑ Scalp ❑ Groin ❑ Nails ❑ Other: _____

Prior Failed Meds: ❑ Biologics ❑ Cimzia ❑ Enbrel ❑ Humira ❑ Orencia ❑ Remicade ❑ Rituxan ❑ Simponi ❑ Stelara

❑ MTX ❑ Soriatane ❑ CYA Length of Treatment_____Reason for Discontinuing _____

❑ PUVA/UVB Length of Treatment _____ Reason for Discontinuing _____

❑ Topicals Length of Treatment _____ Inadequate Response List Specific Names _____

❑ Contraindicated Medication _____ Reason _____

Does patient have a latex allergy? ❑ Yes ❑ No TB/PPD Test given or intended to be given before start? ❑ Yes ❑ No

	PRESCRIPTION INFORMATION		QUANTITY	REFILLS
❑ Enbrel®	❑ 50mg Sureclick ❑ 50mg Prefilled Syringe ❑ 25mg Prefilled Syringe ❑ 25mg Vials	❑ Inject 50mg subcutaneously **TWICE** a week 72-96 hours apart ❑ Inject 50mg subcutaneously **ONCE** a week ❑ Inject 25mg subcutaneously **TWICE** a week 72-96 hours apart ❑ Inject 2-25mg (50mg) on same day **TWICE** a week 72-96 hours apart	4 week supply	_____
❑ Humira®	❑ Psoriasis Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe	❑ Inject 2-40mg (80mg) on Day 1, then 40mg on Day 8, then 40mg every other week ❑ Inject 40mg subcutaneously **EVERY OTHER** week ❑ Inject 40mg subcutaneously **ONCE** a week	Loading Dose 4 week supply	none _____
❑ Remicade® Wt: _____	❑ 100mg Vial	❑ Infuse_____mg at week 0, 2, 6 ❑ Infuse_____mg at every_____weeks	Loading dose	none _____
❑ Simponi®	❑ 50mg SmartJect ❑ 50mg Prefilled Syringe	❑ Inject 50mg subcutaneously once a month as directed	4 week supply	_____
❑ Stelara® Wt: _____	❑ 45mg Prefilled Syringe (**for Patients ≤ 220 lbs**) ❑ 90mg Prefilled Syringe (**for Patients > 220 lbs**)	❑ Inject 45mg on day 0, then week 4, then every 12 weeks ❑ Inject 90mg on day 0, then week 4, then every 12 weeks	4 week supply	_____
❑ Other ___	_____	_____	4 week supply	_____

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

_____ Prescriber's Signature (no stamps) _____ Date _____ If Brand required check ❑ DAW