Apollo Specialty Pharmacy

DERMATOLOGY (I-Z)

Phone: 973-350-6155 Fax: 973-556-1560

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ L40.0 (Psoriasis vulgaris) ☐ L40.8 (Other psoriasis) ☐ L40.9 (Psoriasis, unspecified) ☐ L40.5____ (Psoriatic arthritis) ☐ L73.2 (Hidradenitis Suppurativa) ☐ _____

Diagnosis Date: _____ TB Test: ☐ Yes ☐ No Neg. Test Date: _____ HBV: ☐ Yes ☐ No If yes, currently treated: ☐ Yes ☐ No

BSA affected (%): _____ Affected areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ _____

Prior Therapy ☐ Yes ☐ No _____

Reason for Discontinuation of Therapy _____

Approximate Start Date _____ Approximate End Date _____

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription	Directions	Quantity	Form	Refill
☐ **Otezla®** (apremilast)	☐ Take as directed per package instructions	☐ 55 tablets	☐ 28-day starter pack	0
	☐ Take 30 mg twice daily by mouth ☐ _____	☐ 60 x 30 mg tablets ☐ _____		
☐ **Simponi®** (golimumab) *Psoriatic Arthritis*	☐ Inject 50 mg subq once a month	☐ 1 x 50 mg/0.5mL	☐ SmartJect® Autoinjector ☐ PFS	
☐ **Stelara®** (ustekinumab)	☐ Inject 45 mg subq on Day 1 (≤100 kg) ☐ Inject 90 mg subq on Day 1 (>100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 x 90 mg/mL	☐ PFS	0
	☐ Inject 45 mg subq on Day 29 and every 12 weeks thereafter (≤100 kg) ☐ Inject 90 mg subq on Day 29 and every 12 weeks thereafter (>100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 x 90 mg/mL	☐ PFS	
	Patient eligible for self-administration: ☐ Yes ☐ No			
☐ **Taltz®** (Ixekizumab)	☐ Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subq at week 0, then inject 80 mg subq at week 2	☐ 3 x 80 mg/mL	☐ Autoinjectors ☐ PFS	0
	☐ Weeks 4 - 10: Inject 80 mg subq at week 4 and every two weeks thereafter through week 10	☐ 2 x 80 mg/mL	☐ Autoinjectors ☐ PFS	1
	☐ Week 12 onwards: Inject 80 mg subq at week 12 and every four weeks thereafter	☐ 1 x 80 mg/mL	☐ Autoinjectors ☐ PFS	

Injection training provided by: ☐ Physician's Office ☐ Pharmacy ☐ Other:

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:

Prescriber's Signature: _____ Date: _____

I authorize Apollo Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Apollo Pharmacy.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 973-350-6155 to obtain instructions as to the proper destruction of the transmitted material. Thank you.

Copyright © 2018 by Apollo Pharmacy. All rights reserved.

Reset Form