SPECIALTY PHARMACY

DERMATOLOGY N-Z

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192
krogerspecialtypharmacy.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		

PLEASE FAX COPY OF: ❏ PRESCRIPTION CARD FRONT & BACK ❏ CLINICAL NOTES ❏ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❏ L20.9 Atopic Dermatitis ❏ L40.8 Moderate to Severe Plaque Psoriasis ❏ L40.50 Psoriatic Arthritis ❏ L73.2 Hidradenitis Suppurativa - Hurley Stage ________
❏ Other: Dx code________________________ Condition ____

Drug Allergies: ____

Location: % BSA: ___________________ ❏ Hands ❏ Feet ❏ Scalp ❏ Groin ❏ Nails ❏ Other: ________________________________

Prior Failed Meds: ❏ Biologics ❏ Cimzia ❏ Cosentyx ❏ 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 biologic started)? ❏ Yes ❏ No (PLEASE send LAB result)

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❏ Odomzo®	200mg capsule	Take one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal	30	________
❏ Otezla®	❏ Starter Pack ❏ 30mg Tablets	❏ Titrate: Take 1 tablet on day 1 then twice daily as directed **OR date provided** ________ ❏ Maintenance: Take 1 tablet by mouth twice daily. ❏ Bridge Rx: Take 1 tablet by mouth twice daily; dispensed by OSP	1 Starter Pack 60 28	none ________ 12
❏ Siliq®	210mg Prefilled Syringe	❏ Load: Inject 210mg subcutaneously at weeks 0, 1 and 2, then every 2 weeks thereafter ❏ Maintenance: Inject 210mg subcutaneously every 2 weeks	4 syringes 2 syringes	0 ________
❏ Simponi®	50mg ❏ SmartJect ❏ PFS	Inject 50mg subcutaneously once a month as directed	4 week supply	________
❏ Stelara® Wt: ________	❏ 45mg PFS **(wt. ≤ 220 lbs)** ❏ 90mg PFS **(wt. >220 lbs)**	❏ Starter: Inject 1 syringe subcutaneously on week 0 ❏ Maintenance: Inject 1 syringe subcutaneously on week 4 and then every 12 weeks ❏ Inject ____mg on day 0, then week 4, then every 12 weeks **(for adolescents)**	1 1 1	none ________ ________
❏ Taltz™	❏ 80mg/mL Autoinjector ❏ 80mg/mL Prefilled Syringe	❏ Load: Inject 160mg (2 – 80mg) subcutaneously on week 0, then inject 80mg week 2 then Inject 80mg every 2 weeks (weeks 4-10) then Inject 80mg at week 12 ❏ Load: (Psoriatic Arthritis): Inject 2-80mg (160 mg) subcutaneously on day 1 ❏ Maintenance: Inject 80mg subcutaneously every 4 weeks	3 2 1 2 1	none 1 none none ________
❏ Tremfya™	100mg/mL Prefilled Syringe	❏ Starter: Inject 100mg subcutaneously on week 0 ❏ Maintenance: Inject 100mg subcutaneously on week 4 and then every 8 weeks	1 1	none ________
❏ Other			________	________

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted ____________ Date ________ Prescriber's Signature (no stamps) Dispense As Written ____________ Date ________

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