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 INFORMATION		PRESCRIBER INFORMATION		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❏ Male ❏ Female	Contact Person		

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

CLINICAL INFORMATION

Diagnosis: ❏ L20.9 Atopic Dermatitis ❏ L40.0 Moderate to Severe Plaque Psoriasis ❏ L40.50 Psoriatic Arthritis ❏ L73.2 Hidradenitis Suppurativa - Hurley Stage: ___________
❏ M35.2 Behçet's Disease ❏ Other: Dx code _______________ Condition ____

Drug Allergies: ____ Weight: _______________ ❏ kg ❏ lb

Location: Joints: ❏ Hands ❏ Feet ❏ Knees ❏ Spine Skin: % BSA: _______________ ❏ Hands ❏ Feet ❏ Scalp ❏ Groin ❏ Nails ❏ Other: _______________________

Prior Failed Meds: Biologics: ❏ Cimzia ❏ Cosentyx ❏ Enbrel ❏ Humira ❏ Orencia ❏ Remicade ❏ Simponi ❏ Stelara ❏ Taltz
❏ Methotrexate ❏ Soriatane ❏ Cyclosporine ❏ PUVA/UVB
❏ Topicals (list names): ____ ❏ Other: ____

Does patient have a latex allergy? ❏ No ❏ Yes **TB Test:** ❏ No ❏ Yes Date: ________________ Results: ________________________________ (Please send lab results)

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 Capsules	___________
❏ Otezla®	❏ Starter Pack ❏ 30mg Tablet	Take 1 tablet on day 1 then twice daily as directed **or** date provided _______ ❏ Take 1 tablet by mouth twice daily For Bridge Requests please utilize the Otezla Support Plus Start Form and fax to Kroger SP at 888.355.4192	1 Starter Pack 60 Tablets	None ___________
❏ Siliq®	210mg PFS	❏ Load: Inject 210mg subcutaneously on weeks 0,1, and 2, then every 2 weeks thereafter ❏ Maintenance: Inject 210mg subcutaneously every 2 weeks	4 Syringes 2 Syringes	None ___________
❏ Simponi®	50mg ❏ SmartJect® ❏ PFS	Inject 50mg subcutaneously once a month as directed	1 Dose	___________
❏ Skyrizi™	75mg PFS	❏ Starter: Inject 150mg (as two-75mg syringes) subcutaneously on week 0 ❏ Maintenance: Inject 150mg (as two-75mg syringes) subcutaneously on week 4, then every 12 weeks thereafter	2 Syringes 2 Syringes	None ___________
❏ Stelara®	❏ 45mg PFS *(Weight ≤ 100kg)* ❏ 90mg PFS *(Weight > 100kg)* ❏ 45mg Vial *(For adolescents <60kg)*	❏ Starter: Inject 1 syringe subcutaneously on week 0 ❏ Maintenance: Inject 1 syringe subcutaneously on week 4, and then every 12 weeks thereafter ❏ Starter: Inject __________ mg (0.75mg/kg) subcutaneously on week 0 ❏ Maintenance: Inject __________ mg (0.75mg/kg) subcutaneously on week 4, then every 12 weeks thereafter	1 Syringe 1 Syringe 1 Vial 1 Vial	None ___________ None ___________
❏ Taltz™	80mg ❏ Autoinjector ❏ PFS	❏ Load (Plaque psoriasis): Inject 160mg (as two-80mg injections) subcutaneously on week 0, then 80mg on week 2, then Inject 80mg subcutaneously every 2 weeks (weeks 4-10), then Inject 80mg subcutaneously at week 12 ❏ Load (Psoriatic arthritis): Inject 160mg (as two-80mg injections) subcutaneously on week 0 ❏ Maintenance: Inject 80mg subcutaneously every 4 weeks	3 Doses 2 Doses 1 Dose 2 Doses 1 Dose	None 1 None None ___________
❏ Tremfya™	100mg ❏ One-Press Injector ❏ PFS	❏ Starter: Inject 100mg subcutaneously on week 0 ❏ Maintenance: Inject 100mg subcutaneously on week 4, then every 8 weeks thereafter	1 Dose 1 Dose	None ___________
❏ Xeljanz®	❏ 5mg Tablet ❏ 11mg XR Tablet	Take 1 tablet by mouth twice daily Take 1 tablet by mouth daily	60 Tablets 30 Tablets	___________ ___________
❏ 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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