UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

DERMATOLOGY PRESCRIPTION AND REFERRAL FORM

PATIENT INFORMATION

Please send a copy of ALL of patient's insurance cards including Prescription, Primary and Secondary (both sides) Also include any other beneficial information for prior authorization and dispensing assessments.

Patient Name _____ **DOB** _____ **Gender** ☐ Male ☐ Female

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work phone** _____ **Email** _____

Primary Language ☐ English ☐ Spanish ☐ Other specify_____ **Allergies** _____

RX Member ID _____ **RX Group ID** _____ **RX PCN** _____ **RX BIN**_____

CLINICAL INFORMATION / PATIENT HISTORY (PLEASE SUBMIT SUPPORTING DOCUMENTATION)

Height:	Weight:	Diagnosis / Primary ICD-10 Code:	
Date of labs obtained: __/___/__	SCr:	TB Skin Test Result Date:	TB Skin Test Result:

Previous Therapy:

PRESCRIPTION INFORMATION

☐ **Cosentyx®** (Secukinumab) ☐ 150mg Prefilled Syringe ☐ 150mg Pen

Sig: ☐ 150mg ☐ 300mg Inject sub-q ONCE at weeks 0, 1, 2, 3, and 4 — Disp. 1 month supply — No Refills

☐ 150mg ☐ 300mg Inject sub-q ONCE every FOUR weeks — Disp. 1 month supply — Refills: #

☐ **Dupixent®** (Dupilumab) ☐ 300 mg Prefilled Syringe

Sig: ☐ Inject 600 mg sub-q once, then 300 mg sub-q every other week — Disp. 1 month supply — Refills: #___

☐ Inject 300 mg sub-q every other week (maintenance dose) — Disp. 1 month supply — Refills: #___

☐ **Enbrel®** (Etanercept) ☐ 25mg Vial ☐ 25mg Prefilled Syringe ☐ 50mg SureClick™ Autoinjector ☐ 50mg Prefilled Syringe

Sig: ☐ Inject 50mg sub-q TWICE weekly for 3 months — Disp. 3 month supply — No Refills

☐ Inject 50mg sub-q ONCE a week — Disp. 1 month supply — Refills: #___

☐ Inject 25mg sub-q TWICE a week (72-96 hours apart)

☐ **Humira®** (Adalimumab) ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Starter Pen Package

Sig: ☐ Inject 80mg sub-q ONCE, then 40mg sub-q every OTHER week starting 1 week after initial dose — Disp. 1 month supply — No Refills

☐ Inject 40mg sub-q every OTHER week — Disp. 1 month supply — Refills: #___

☐ Inject 160mg sub-q ONCE on Day 1. Inject 80mg ONCE on Day 15. Inject 40mg sub-q ONCE on Day 29 then weekly thereafter — Disp. 1 month supply — Refills: #___

☐ Other:_____ — Disp. 1 month supply — Refills: #___

☐ **Otezla®** (Apremilast) ☐ 30 mg tabs ☐ 4 week Starter pack **OR** ☐ Starter pack sample provided by prescriber

Sig: ☐ Take by mouth :
Day 1: 10mg AM
Day 2: 10mg BID
Day 3: 10mg AM, 20mg PM
Day 4: 20mg BID
Day 5: 20mg AM, 30mg PM
Day 6-28: 30mg BID
— Disp. 55 tab pack — No Refills

☐ Take one tablet by mouth TWICE daily (Maintenance) — Disp. 60 tablets — Refills: #___

☐ Take one tablet by mouth ONCE daily (Renal Dosing) — Disp. 30 tablets — Refills: #___

☐ **Stelara®** (Ustekinumab) ☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/ml Prefilled Syringe

Sig: ☐ Inject 45mg sub-q on Day 1 and 29 — Disp. 1 month supply — No Refills

(Weight 100 kg or less) ☐ Inject 45mg sub-q once every 3 months — Disp. 3 month supply — Refills: # __

Sig: ☐ Inject 90mg sub-q on Day 1 and 29 — Disp. 1 month supply — No Refills

(Weight greater than 100 kg) ☐ Inject 90mg sub-q once every 3 months — Disp. 3 month supply — Refills: # ___

☐ **OTHER**_____

BY SIGNING BELOW, I CERTIFY THAT THE ABOVE THERAPY IS MEDICALLY NECESSARY.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's Signature: (No Stamps)		**DATE:**	

Print Prescriber's Name:_____ NPI: _____ Phone_____

Address _____City_____ State _____ Fax _____