Spring Creek Pharmacy

DERMATOLOGY
Phone: 972-517-7900
Fax: 972-517-0400
280 Legacy Drive #102 Plano,TX 75023

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

PATIENT INFORMATION

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

PRESCRIBER INFORMATION

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 Code: ❑ 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
❑ 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 _____
❑ 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	_____
❑ 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	_____
❑ Simponi®	❑ 50mg SmartJect ❑ 45mg Prefilled Syringe	❑ Inject 50mg subcutaneously once a month as directed	4 Week Supply	_____
❑ Remicade® Wt: _____	❑ 100mg Vial	❑ Infuse _____mg at week 0, 2, 6 ❑ Infuse _____mg at every _____ weeks	Loading Dose _____	None _____
❑ Otezla®	❑ Starter Pack ❑ 30mg Tablets	❑ Titration: Take 1 tablet on day 1 then twice daily as directed ❑ Take 1 tablet by mouth twice daily	1 Starter Pack 60	None _____
❑ Erivedge®	❑ 150mg Capsule	❑ Take one capsule by mouth daily	4 week supply	_____
❑ Other ____	_____	_____	4 Week Supply	_____

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

By signing this form and utilizing our services, you are authorizing Blake Pharmacy and it's emplyees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

REV-6.17.15