



Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1 st Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID #: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite #: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis ICD-10: <input type="checkbox"/> L40.0 (Psoriasis vulgaris) <input type="checkbox"/> L40.8 (Other psoriasis) <input type="checkbox"/> L40.9 (Psoriasis, unspecified) <input type="checkbox"/> L40.5 (Psoriatic arthritis) <input type="checkbox"/> L73.2 (Hidradenitis Suppurativa) <input type="checkbox"/> Other: _____ TB/PDD test given: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Neg. Test: _____ HBV Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, patient currently treated: <input type="checkbox"/> Yes <input type="checkbox"/> No Prior Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes (Provide Information Below) BSA affected (%): _____ Affected areas: <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia <input type="checkbox"/> Other: _____			
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	
<input type="checkbox"/> Cimzia® (Only for PsA)	Starter: <input type="checkbox"/> Inject 400 mg Sub-Q at weeks 0, 2 and 4 Qty: <input type="checkbox"/> 1 starter kit (6 x 200mg/mL PFS) <input type="checkbox"/> 3 cartons (2 x 200mg/mL vials/carton) Maintenance: <input type="checkbox"/> Inject 400 mg Sub-Q every 4 weeks <input type="checkbox"/> Inject 200 mg Sub-Q every 2 weeks Qty: 1 carton (2 x 200 mg/mL) <input type="checkbox"/> PFS <input type="checkbox"/> Vials Refills: _____
<input type="checkbox"/> Cosentyx®	To order Cosentyx® please see the Novartis service request form at cosentyxhcp.com/get-your-patients-started To ensure prescription is forwarded to Rx International, specify Rx International as the preferred specialty pharmacy.
<input type="checkbox"/> Enbrel®	Starter: <input type="checkbox"/> Inject 50 mg Sub-Q twice a week (72-96 hours apart) x 3 months Qty: 2 cartons (4x50 mg/mL) <input type="checkbox"/> SureClick® <input type="checkbox"/> PFS Refills: 2 Maintenance: <input type="checkbox"/> Inject 50 mg Sub-Q every week Qty: 1 carton (4x50 mg/mL) <input type="checkbox"/> SureClick® <input type="checkbox"/> PFS Refills: _____
<input type="checkbox"/> Humira® (Plaque Psoriasis)	Starter: <input type="checkbox"/> Inject 80 mg Sub-Q Day 1, then 40 mg on Day 8, then 40 mg every 2 weeks thereafter Qty: <input type="checkbox"/> 1 carton (4x40 mg/0.8mL) Pens <input type="checkbox"/> 2 carton (2x40 mg/0.8mL) PFS Maintenance: <input type="checkbox"/> 40 mg SQ every 2 weeks Qty: 1 carton (2x40 mg/0.8mL) <input type="checkbox"/> Pens <input type="checkbox"/> PFS Refills: _____
<input type="checkbox"/> Humira® (Hidradenitis Suppurativa)	Starter: <input type="checkbox"/> Inject 160 mg SQ Day 1 (or 80 mg SQ on Day 1 and Day 2); then 80mg on Day 15 Qty: 1 carton (6x40 mg/0.8mL) <input type="checkbox"/> Pens <input type="checkbox"/> PFS Maintenance: <input type="checkbox"/> Starting on Day 29, 40 mg SQ every week Qty: 2 cartons (2x40 mg/0.8mL) <input type="checkbox"/> Pens <input type="checkbox"/> PFS Refills: _____
<input type="checkbox"/> Otezla®	Starter: <input type="checkbox"/> Take as directed per package instructions Qty: 55 tablets (One 28-day pack) Maintenance: <input type="checkbox"/> Take 30 mg twice daily by mouth <input type="checkbox"/> _____ Qty: <input type="checkbox"/> 60 tablets <input type="checkbox"/> _____ Refills: _____
<input type="checkbox"/> Simponi® (Only for PsA)	<input type="checkbox"/> Inject 50 mg Sub-Q once a month Qty: 1 carton (1x50 mg/0.5mL) <input type="checkbox"/> Pens <input type="checkbox"/> PFS Refills: _____
<input type="checkbox"/> Stelara®	Starter: <input type="checkbox"/> Inject 45 mg/0.5mL Sub-Q on Day 1 (≤100 kg) <input type="checkbox"/> Inject 90 mg/1 mL Sub-Q on Day 1 (>100 kg) Qty: 1 PFS Refills: 0 Maintenance: <input type="checkbox"/> Inject 45 mg/0.5 mL Sub-Q on Day 29 and every 12 weeks thereafter (≤100 kg) <input type="checkbox"/> Inject 90 mg/1 mL Sub-Q on Day 29 and every 12 weeks thereafter (>100 kg) Qty: 1 PFS Refills: _____ Patient eligible for self-injection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Injection Training Provided by: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other: _____	
Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____	
Prescriber's Signature: _____ Date: _____ <small>I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.</small>	

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