Dermatology

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____❑cm ❑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 + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite #_____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to prescriber: ❑ 1st Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis ICD-10: ❑ L40.0 (Psoriasis vulgaris) ❑ L40.8 (Other psoriasis) ❑ L40.9 (Psoriasis, unspecified) ❑ L40.5___ (Psoriatic arthritis)
❑ L73.2 (Hidradenitis Suppurativa) ❑ Other: _____ TB/PDD test given: ❑ Yes ❑ No Date of Neg. Test: _____
HBV Positive: ❑ Yes ❑ No If yes, patient currently treated: ❑ Yes ❑ No Prior Treatment? ❑ No ❑ Yes (Provide Information Below)
BSA affected (%): _____ Affected areas: ❑ Palms ❑ Soles ❑ Head ❑ Neck ❑ Genitalia ❑ Other: _____

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

❑ Cimzia® **(Only for PsA)**

Starter: ❑ Inject 400 mg Sub-Q at weeks 0, 2 and 4
Qty: ❑ 1 starter kit (6 x 200mg/mL PFS) ❑ 3 cartons (2 x 200mg/mL vials/carton)

Maintenance: ❑ Inject 400 mg Sub-Q every 4 weeks ❑ Inject 200 mg Sub-Q every 2 weeks
Qty: 1 carton (2 x 200 mg/mL) ❑ PFS ❑ Vials Refills: _____

❑ 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.

❑ Enbrel®

Starter: ❑ Inject 50 mg Sub-Q twice a week (72-96 hours apart) x 3 months
Qty: 2 cartons (4x50 mg/mL) ❑ SureClick® ❑ PFS Refills: 2

Maintenance: ❑ Inject 50 mg Sub-Q every week
Qty: 1 carton (4x50 mg/mL) ❑ SureClick® ❑ PFS Refills: _____

❑ Humira® **(Plaque Psoriasis)**

Starter: ❑ Inject 80 mg Sub-Q Day 1, then 40 mg on Day 8, then 40 mg every 2 weeks thereafter
Qty: ❑ 1 carton (4x40 mg/0.8mL) Pens ❑ 2 carton (2x40 mg/0.8mL) PFS

Maintenance: ❑ 40 mg SQ every 2 weeks
Qty: 1 carton (2x40 mg/0.8mL) ❑ Pens ❑ PFS Refills: _____

❑ Humira® **(Hidradenitis Suppurativa)**

Starter: ❑ 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) ❑ Pens ❑ PFS

Maintenance: ❑ Starting on Day 29, 40 mg SQ every week
Qty: 2 cartons (2x40 mg/0.8mL) ❑ Pens ❑ PFS Refills:_____

❑ Otezla®

Starter: ❑ Take as directed per package instructions
Qty: 55 tablets (One 28-day pack)

Maintenance: ❑ Take 30 mg twice daily by mouth ❑ _____
Qty: ❑ 60 tablets ❑_____ Refills:_____

❑ Simponi® **(Only for PsA)**

❑ Inject 50 mg Sub-Q once a month
Qty: 1 carton (1x50 mg/0.5mL) ❑ Pens ❑ PFS Refills:_____

❑ Stelara®

Starter: ❑ Inject 45 mg/0.5mL Sub-Q on Day 1 (≤100 kg)
❑ Inject 90 mg/1 mL Sub-Q on Day 1 (>100 kg)
Qty: 1 PFS Refills: 0

Maintenance: ❑ Inject 45 mg/0.5 mL Sub-Q on Day 29 and every 12 weeks thereafter (≤100 kg)
❑ 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: ❑ Yes ❑ No

Injection Training Provided by: ❑ Physician's Office ❑ Pharmacy ❑ Other: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.