APEX SPECIALTY PHARMACY

PLAQUE PSORIASIS
PSORIATIC ARTHRITIS

Phone: 855.257.2584 || Fax: 866.680.3539

Date _____
☐ NEW START
☐ CONTINUATION, Start Date: _____

PATIENT INFORMATION

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10)
☐ L20. ____ Atopic Dermatitis ☐ C44.____ Basal Cell Carcinoma ☐ L73.2 Hidradenitis Suppurativa
☐ L74.51 ____ Hyperhidrosis ☐ L40. ____ Plaque Psoriasis ☐ L40. ____ Psoriatic Arthritis ☐ L50.____ Urticaria

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

Tried/Failed Therapies
☐ Cimzia ☐ Cosentyx ☐ Cyclosporine ☐ Enbrel ☐ Humira ☐ Ilumya ☐ Methotrexate ☐ Orencia ☐ Otezla
☐ PUVA/UVB ☐ Remicade ☐ Simponi ☐ Skyrizi ☐ Sotyktu ☐ Stelara ☐ Taltz ☐ Tremfya

BSA: _____% ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Other Areas _____
PPD/Chest X-Ray for TB? ☐ Yes ☐ No Drug Allergies: _____

PRESCRIPTION INFORMATION

☐ Cimzia	☐ 200x2 PFS ☐ 200x2 LYO	☐ Start: Inject 400mg at weeks 0, 2, and 4 (qty 3 kits) ☐ Maint: Inject ____mg every: ☐ 2 ☐ 4 wks (qty ____) ***Pt. weight ____ lbs***	Refill: 0 Refill:
☐ Cosentyx	☐ 150mg Sensoready PEN ☐ 150mg Syringe	☐ Start: Inject 2-150mg (300mg) at Weeks 0, 1, 2, 3, and 4 ☐ Maint: Inject 2-150mg (300mg) every 4 weeks ***Pt. weight ____ lbs***	Refill: 0 Refill:
☐ Enbrel	☐ 50mg Enbrel Mini ☐ 50mg Sureclick ☐ 50mg Syringe ☐ 0.8 mg/kg	☐ Inject 50mg SQ TWICE a week, 72-96 hours apart (qty 8) for 12 weeks ☐ Inject 50mg SQ ONCE a week (qty 4) ☐ Inject 0.8 mg/kg ONCE a week (qty 4) ***Pt. weight ____ lbs***	Refill:
☐ Humira Starter Kit ☐ Amjevita Starter Kit	☐ 80mg/0.8ml (qty 1) and 40/0.4ml PEN (qty 2) ☐ 80mg/0.8ml PEN (qty 3)	☐ Inject 80mg SQ on Day 1, then 40mg SQ on Day 8, then 40mg every other week ☐ Inject 160mg SQ on Day 1, then 80mg on Day 15	Refill: 0
☐ Humira Maintenance ☐ Amjevita Maintenance	☐ 40mg/0.4ml PEN ☐ 40mg/0.4ml Syringe ☐ 80mg/0.8ml PEN	☐ Inject 40mg SQ every ____ week(s) (qty ____) ☐ Inject 80mg SQ every ____ week(s) (qty ____)	Refill:
☐ Ilumya	☐ 100mg/ml Syringe	☐ Start: Inject 100mg SQ at week 0 and week 4, then every 12 weeks (qty 2)	Refill:
☐ Odomzo	☐ 200mg Capsule	☐ Take 1 Capsule ONCE daily on an empty stomach	Refill:
☐ Otezla	☐ Starter Kit ☐ 30mg Tablet	☐ Take Starter Dosing per instructions (qty 55 // 28 days) [☐ *Office provided*] ☐ Take 1 tablet by mouth twice daily (qty 60 // 30 days)	Refill: 0 Refill:
☐ Sotyktu	☐ 6mg Tablet	☐ Take 1 tablet by mouth daily	Refill:
☐ Skyrizi	☐ 150mg Syringe ☐ 150mg PEN	☐ Inject 150mg Day O, then on Day 28 ☐ Inject 150mg Every 12 Weeks	Refill:
☐ Stelara	☐ 45mg Syringe ☐ 90mg Syringe	☐ Start: Inject ____mg SQ day 0, then on day 28 ☐ Maint: Inject ____mg SQ every 12 weeks ***Pt. weight ____lbs***	Refill: 0 Refill:
☐ Taltz	☐ 80mg Autoinjector ☐ 80mg Syringe	☐ Start: Inject 160mg SQ at Week 0, then 80mg at Weeks 2, 4, 6, 8, 10, 12 ☐ Maint: Inject 80mg SQ every 4 weeks ***Pt. weight ____lbs***	Refill: 0 Refill:
☐ Tremfya	☐ 100mg Autoinjector ☐ 100mg Syringe	☐ Start: Inject 100mg SQ at Week 0, then on day 28 ☐ Maint: Inject 100mg SQ every 8 weeks	Refill: 0 Refill:

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN