

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information		
Last Name	First Name	DOB	Practice/Facility Name					
Address			Address					
City	State	ZIP	City	State	ZIP			
SSN			Prescriber Name					
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (kg)	Height (ft,in)	Prescriber NPI					
Emergency Contact		Phone	Nurse/Key Contact		Phone/Pager			
Insurance Plan	Plan ID #		Fax					

Diagnosis/Clinical Information			PLEASE FAX CLINICAL AND LAB INFORMATION		
Diagnosis: L20.____ Atopic Dermatitis	L40.0 Psoriasis vulgaris/Plaque psoriasis/Nummular psoriasis	L40.8 Other psoriasis			
L40.9 Psoriasis, unspecified	L40.5___ Psoriatic arthritis	L73.2 Hidradenitis Suppurativa	Other: _____		
Date of diagnosis or years with the disease: _____					
Active TB is ruled out: Yes No Date of negative TB test: ____/____/____					
Concomitant medications: _____					
Previous treatment regimens with dates and reason for discontinuation: _____					

Prescription Information					
DRUG	DOSAGE/STRENGTH	DIRECTIONS	QTY	REFILLS	
Cimzia <small>(Vials to be prepared and administered by healthcare professionals)</small>	<input type="checkbox"/> 200mg/mL Prefilled Syringes	Starter Dose: <input type="checkbox"/> Inject 400mg SQ at weeks 0, 2 and 4	6	0	
	<input type="checkbox"/> 200mg/mL Vials	Maintenance Dose: <input type="checkbox"/> Inject 400mg SQ every 4 weeks <input type="checkbox"/> Inject 200mg SQ every 2 weeks	28 day		
Cosentyx	<input type="checkbox"/> 150mg/mL Sensoready Pen	Starter Dose: <input type="checkbox"/> Inject 300mg SQ once weekly at weeks 0, 1, 2, 3 and 4 <input type="checkbox"/> Inject 150mg SQ once weekly at weeks 0, 1, 2, 3 and 4	10	0	
	<input type="checkbox"/> 150mg/mL Prefilled Syringe	Maintenance: <input type="checkbox"/> Inject 300mg SQ every 4 weeks <input type="checkbox"/> Inject 150mg SQ every 4 weeks	5		
Enbrel	<input type="checkbox"/> 50mg/mL Sureclick Autoinjector	Starter Dose: <input type="checkbox"/> Inject 50mg SQ twice a week (72-96 hrs apart) x 3 months (Psoriasis) <input type="checkbox"/> Other:	28 day	2	
	<input type="checkbox"/> 50mg/mL Prefilled Syringe <input type="checkbox"/> 25mg/0.5mL Prefilled Syringe <input type="checkbox"/> 25mg/mL vial <input type="checkbox"/> Enbrel® Mini	Maintenance Dose: <input type="checkbox"/> Inject 50mg SQ once weekly <input type="checkbox"/> Inject 25mg SQ twice weekly (72-96 hrs apart) <input type="checkbox"/> Other:	28 day		
Humira	<input type="checkbox"/> 40mg/0.8mL Pens	<input type="checkbox"/> Psoriasis Starter Pack: Inject 80mg SQ Day 1, then 40mg on Day 8, then 40mg every other week thereafter	4	0	
	<input type="checkbox"/> 40mg/0.8mL Prefilled Syringes	Hidradenitis Suppurativa: <input type="checkbox"/> Inject 160mg SQ on Day 1, 80mg SQ on Day 15, then 40mg every week thereafter -OR- <input type="checkbox"/> Inject 80mg SQ on Day 1 and Day 2, 80mg SQ on Day 15, then 40mg every week thereafter	6	0	
		Maintenance Dose: <input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Inject 40mg SQ on day 29 and every week thereafter (Hidradenitis Suppurativa)	28 day		

Date needed: ____/____/____ Medication delivery to (choose one): Prescriber Home Other: _____

Injection training to be provided by: Prescriber's Office Hy-Vee Pharmacy Solutions Other: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____ DISPENSE AS WRITTEN/Do Not Substitute (date) _____

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