HOME PARENTERAL SERVICES

Dermatology (drugs A-E)

(Cimzia ˚, Cosentyx ˚, Dupixent ˚, Enbrel ˚)

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
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: _____
If shipping to prescriber: ❑ First Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent 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) ❑ _____

Diagnosis Date: _____ TB test: ❑ Yes ❑ No Neg. Test Date: _____ HBV: ❑ Yes ❑ No If yes, currently treated: ❑ Yes ❑ No
BSA affected (%): _____ Affected areas: ❑ Palms ❑ Soles ❑ Head ❑ Neck ❑ Genitalia ❑ _____

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

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

Has the patient received their starter dose(s)/kit? Yes; Start Date _____ No

Prescription		Quantity		Refill
❑ **Cimzia®** **(certolizumab)** *Psoriatic Arthritis*	❑ Inject 400 mg subq at weeks 0, 2 and 4	6 x 200 mg/mL	❑PFS ❑Vials	0
	❑ Inject 200 mg subq every 2 weeks ❑ Inject 400 mg subq every 4 weeks	2 x 200 mg/mL	❑ PFS ❑ Vials	_____
❑ **Cosentyx®** **(secukinumab)**	❑ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3	4 x 150 mg/mL	❑ Sensoready® Pen ❑ PFS	0
	❑ Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3	8 x 150 mg/mL		
	❑ Inject 150 mg subq on week 4 and every 4 weeks thereafter	1 x 150 mg/mL	❑ Sensoready® Pen ❑ PFS	_____
	❑ Inject 300 mg subq on week 4 and every 4 weeks thereafter	2 x 150 mg/mL		
❑ **Dupixent®** **(dupilumab)**	❑ Inject 600mg subq on day 1, followed by 300mg subq on day 15, and every 2 weeks thereafter	4 x 300 mg/2 mL	PFS	0
	❑ Inject 300mg subq every 2 weeks	2 x 300 mg/2 mL	PFS	_____
❑ **Enbrel®** **(etanercept)** *Adult*	❑ Inject 50 mg subq twice a week (72-96 hours apart) for 3 months	8 x 50 mg/mL	❑ SureClick ® Autoinjector ❑ Mini™ Cartridge PFS	2
	❑ Inject 50 mg subq every week	4 x 50 mg/mL	❑ SureClick® Autoinjector ❑ Mini™ Cartridge PFS	_____

§ Humira®, Orencia®, Otezla® , Siliq™, Simponi®, Simponi Aria®, Stelara®, Taltz®, and Tremfya™ are listed alphabetically on respective enrollment forms.§

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

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:

Prescriber's Signature: _____ Date: _____

Substitution Permitted _____ Dispense as Written

I authorize Home Parenteral Services. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.