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	SERVICES

Dermatology (drugs A-E) PHONE: 1-800-637-9201

Apt/Suite:	Patient name: DOB: Prescriber name: Sex: Female I Male SN: Ikg Ibs Ht; Icm In Address: Wt: State: Zip: Apt/Suite: City: State: Zip: Apt/Suite: City: State: Zip: Phone: Phone: Phone: Alternate: Insurance plan: Phone: Fax: Email: Insurance plan: Plan ID: If shipping to prescriber: First Fill Always Never Please fax a copy of front and back of the insurance card(s). If shipping to prescriber: First Fill Always Never Please fax a copy of front and back of the insurance card(s). If shipping to prescriber: First Fill Always Never Please fax a copy of front and back of the insurance card(s). If shipping to prescriber: First Fill Always Never Diagnosis: L 20 (Atopic Dermatitis) IL 40. (Portiasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) IL 40.8 (Other psoriasis Diagnosis Date:	Patient name:		SERVICES	5	(Cimzia °, Cosentyx °,	Dupixent [•] , Enbrel [•])	FAX: 1-417-269	-0692
Sex: □ Female □ Male SN:: NPI: Language: Wt: □ kg □lbs Ht: □ cm □in Address:: Address:: Apt/Suite: _ City: _ State: _ Zip: _ Phone: Alternate: Caregiver name: Relation: Local pharmacy: Phone: Insurance plan: Plan ID. Please fax: a copy of forting back of the insurance card(s). Clinical Information (Please fax all pertinent clinical and lab information) Diagnosis: L20. (Atopic Dermatilis) □ L40.0 (Psorials vulgaris/Plaque Psoriasis/Nummular Psoriasis) □ L40.8 (Other psoriasis unspecified) □ L40.5 (Psorial carthritis) □ L73.2 (Hidradentits Supprativa) □ Diagnosis: L20. (Atopic Dermatilis) L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) L40.8 (Other psoriasis) Diagnosis: L20. (Atopic Dermatilis) L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) L40.8 (Other psoriasis) Barbon: TB test: □ Yes □ No Neg. Test Date: HBV. Yes □ No If yes, currently treated: □ Yes □ No Barbon: Affected areas: □ Palms □ Soles □ Head □ Neck □ Genitalia □ Approximate End Date Prior Therapy Yes □ No Reason for Discontinuation of Therapy Approximate Start Date Approximate Comorbidities:	Sex: Pernale D Male SN: NPI: Language: Wt: Ukg Dibs Ht: Corm Address: Apt/Suite: City: State: Zip: Apt/Suite: City: State: Zip: Phone: Alternate: Phone: Alternate: Phone: Alternate: Phone: Alternate: Phone: Alternate: Phone:	Sex: Female D Male SSN: Male SSN: Male SSN: Language: Wt Bills Ht: Common Male Address: Address: Address: Address: Address: Apt/Suite: City: State: Zip: Phone: Alternate: Phone: Phone: Alternate: Caregiver name: Relation: Fax: Email: Male SV Insurance plan: Phone: Fax: Email: Male SV Insurance plan: Phone: Fax: Email: Male SV Diagnosis: LO: (Altor Dermattis) L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) 140.8 (Other psori Bas Affected (Ps): T Btest: Yes No Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date Prior Therapy Yes No Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date Comorbidities: Comorbidities: Comorbidities: Valis Valis Valis Comorbidities: Comorbidities: Male 200 mg subg avery2 weeks 2 x 200 mg/mL PFS Valis <td>Pati</td> <td>ient Informati</td> <td>on</td> <td></td> <td>Prescriber +</td> <td>Shipping Inform</td> <td>nation</td> <td></td>	Pati	ient Informati	on		Prescriber +	Shipping Inform	nation	
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Allergies: NKDA Other: No Has the patient received their starter dose(s)/kit? Yes; Start Date No Prescription Quantity PFS (certolizumab) Inject 400 mg subq at weeks 0, 2 and 4 6 x 200 mg/mL PFS // certolizumab) Inject 200 mg subq every 2 weeks 2 x 200 mg/mL PFS // cortolizumabi Inject 400 mg subq once weekly at weeks 0, 1, 2 and 3 4 x 150 mg/mL Sensoready® Pen // cosentyx® Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 8 x 150 mg/mL PFS // cosentyx® Inject 150 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready® Pen // lnject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready® Pen // lnject 300 mg subq on day 1, followed by 300mg subq on day 15, and every 2 weeks thereafter 1 x 150 mg/mL PFS // dupilumabi Inject 50 mg subq twice a week (72-96 hours apart) for 3 months 8 x 50 mg/mL PFS // lnject 50 mg subq every week 4 x 50 mg/mL SureClick® Autoinjector PFS	Allergies: NKDA Other: No Has the patient received their starter dose(s)/kit? Yes; Start Date No Prescription Quantity PFS (certolizumab) Inject 400 mg subq every 2 weeks 2 x 200 mg/mL PFS Procescription Inject 400 mg subq every 2 weeks 2 x 200 mg/mL PFS Scienciatic Arthritis Inject 400 mg subq every 4 weeks 2 x 200 mg/mL PFS Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3 4 x 150 mg/mL Sensoready [®] Pen 0 Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3 8 x 150 mg/mL Sensoready [®] Pen 0 Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3 8 x 150 mg/mL Sensoready [®] Pen 0 Inject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready [®] Pen 0 Inject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready [®] Pen 0 Inject 300 mg subq on day 1, followed by 300mg subq on day 15, and every 2 weeks thereafter 1 x 150 mg/mL PFS 0 Inject 50 mg subq every 2 weeks 1 nject 300 mg subq every 2 weeks 2 x 300 mg/2 mL PFS 2 Inject 50 mg subq every wee	Allergies: NKDA Other: No Has the patient received their starter dose(s)/kit? Yes; Start Date No Prescription Quantity PFS Cimzia® Inject 400 mg subq at weeks 0, 2 and 4 6 x 200 mg/mL PFS Product their starter dose(s)/kit? Inject 200 mg subq every 2 weeks 2 x 200 mg/mL PFS Psoriatic Arthritis Inject 400 mg subq every 2 weeks 2 x 200 mg/mL PFS Cosentyx® Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 4 x 150 mg/mL Sensoready® Pen Inject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready® Pen Inject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready® Pen Inject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL Sensoready® Pen Inject 500 mg subq on week 4 and every 4 weeks thereafter 2 x 150 mg/mL PFS Inject 300 mg subq on day 1, followed by 300mg subq on day 15, and every 2 weeks 4 x 300 mg//mL PFS Inject 50 mg subq twice a week (72-96 hours apart) for 3 months 8 x 50 mg/mL SureClick * Autoinjector Nini* Cartridge PFS <	Com	norbidities:						
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Prescription Quantity Refil □ Cimzia® (certolizumab) Psoriatic Arthritis □ Inject 400 mg subq every 2 weeks □ Inject 200 mg subq every 2 weeks 0 □ Cosentyx® (secukinumab) □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 □ Inject 150 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL □ PFS □ Sensoready® Pen □ PFS 0 □ Dupixent® (dupilumab) □ Inject 500 mg subq on day 1, followed by 300mg subq on day 15, and every 2 weeks 1 x 150 mg/mL □ Inject 50 mg subq every 2 weeks PFS 0 □ Enbrel® (etanercept) Adult □ Inject 50 mg subq every week 1 nject 50 mg subq every week 1 nject 50 mg subq every week 8 x 50 mg/mL □ SureClick ® Autoinjector □ Mini™ Cartridge 2 PFS	Prescription Quantity Refil □ 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 2 weeks 2 x 200 mg/mL □ PFS □ Vials 0 □ Cosentyx® (secukinumab) □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 4 x 150 mg/mL □ Sensoready® Pen 0 □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 0 × 150 mg/mL □ PFS 0 □ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 8 x 150 mg/mL □ Sensoready® Pen 0 □ Inject 300 mg subq on week 4 and every 4 weeks thereafter 1 x 150 mg/mL □ Sensoready® Pen 0 □ Inject 300 mg subq on week 4 and every 4 weeks thereafter 2 x 150 mg/mL □ PFS 0 □ Inject 300 mg 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 50 mg subq every 2 weeks 2 x 300 mg/2 mL PFS	Prescription Quantity R Cimzia® Inject 400 mg subq at weeks 0, 2 and 4 6 x 200 mg/mL IPFS (certolizumab) Inject 200 mg subq every 2 weeks 2 x 200 mg/mL IPFS Vials IVials	Allei	rgies: NKDA	Other:					
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	PFS P				□ Inject 50 mg s	ubq every week		4 x 50 mg/mL		
PES		§ Humira®, Orencia®, Otezla® , Siliq™, Simponi®, Simponi Aria®, Stelara®, Taltz®, and Tremfya™ are listed alphabetically on respective enrollment form			□ Inject 50 mg s	ubq every week		4 x 50 mg/m∟		
			§н	umira® Orencia®	Otezla® Silia™ Si	mponi® Simponi Aria® Stelara® Ta	ltz® and Tremfva [™] a	are listed alphabetical	lly on respective enrollment :	forms &
§ Humira® Orencia® Ofezla® Silia™ Simponi® Simponi Aria® Stelara® Taltz® and Tremfya™ are listed alphabetically on respective enrollment forms §	§ Humira® Orencia® Otezla® Silia™ Simponi® Simponi Aria® Stelara® Taltz® and Tremfva™ are listed alphabetically on respective enrollment forms §				-		-			1011113.3
	§ 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:	Injection Training Provided by: Physician's Office HPS Other:	Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:	Per s	tate-specific law,	prescriptions will	be dispensed as generic, if application	able, unless notate	ed otherwise:		
Injection Training Provided by: Physician's Office HPS Other:	Injection Training Provided by: Physician's Office HPS Other:									
Injection Training Provided by: Physician's Office HPS Other:	Injection Training Provided by: Physician's Office HPS Other:	Prescriber's Signature: Date:	Presc	riber's Signature:					Date:	
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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: Date: 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	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: Date: Date: Lauthorize 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.			a falle a second a se	encodered Bakada Islanda - Long January 191, 201, 201, 201, 201, 201, 201, 201, 20				

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