HOME PARENTERAL SERVICES

Dermatology (drugs S)

(Siliq ™, Simponi ®, Simponi Aria ®, Stelara ®)

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: ❑ 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
	See forms A-E, F-R, and T-Z for their respecitve medications			
❑ **Siliq™ (brodalumab)**	❑ Inject 210 mg subq on weeks 0, 1, and 2 followed by 210 mg every 2 weeks thereafter	4 x 210 mg/1.5 mL	PFS	0
	❑ Inject 210 mg subq every 2 weeks	2 x 210 mg/1.5 mL	PFS	_____
❑ **Simponi® (golimumab)** *Psoriatic Arthritis*	Inject 50 mg subq once a month	1 x 50 mg/0.5 mL	❑ SmartJect Autoinjector ❑ PFS	_____
❑ **Simponi Aria® (golimumab)**	❑ Infuse _____ mg (2 mg/kg x _____ kg) IV over 30 min at weeks 0	_____ x 50 mg/4 ml	Vials	0
	❑ Infuse _____ mg (2 mg/kg x _____ kg) IV over 30 min at week 4 and every 8 weeks thereafter	_____ x 50 mg/4 ml	Vials	_____
❑ **Stelara®** (ustekinumab) *Adult*	❑ Inject 45 mg subq on Day 1 (≤100 kg) ❑ Inject 90 mg subq on Day 1 (>100 kg)	1 x 45 mg/0.5 mL 1 x 90 mg/1 mL	PFS	0
	❑ Inject 45 mg subq on Day 29 and every 12 weeks thereafter (≤100 kg) ❑ Inject 90 mg subq on Day 29 and every 12 weeks thereafter (>100 kg)	1 x 45 mg/0.5 mL 1 x 90 mg/1 mL	PFS	_____

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

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

Stamp signature not allowed, physician signature required.

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.