CoxHealth at Home

Dermatology (drugs F-R)

PHONE: 1-855-419-4663
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
	§ Cimzia®, Cosentyx®, Dupixent®, and Enbrel® are listed alphabetically on respective enrollment forms.§			
❑ **Humira® Citrate free (adalimumab)**	**Plaque Psoriasis** ❑ Initial: Inject 80mg subq on day 1, then 40mg on day 8 then 40mg on day 22 ❑ Maintenance: Inject 40mg subq every 2 weeks _____	1 x 80 mg/0.8 mL and 2 x 40 mg/0.4 mL 2 x 40 mg/0.4 mL	Pens	0 _____
	Hidradenitis Suppurativa ❑ Initial: Inject 160mg subq on day 1, then 80mg on day 15 ❑ Maintenance: Inject 40mg subq every 2 weeks	2 x 80 mg/0.8 mL and 1 x 40 mg/0.4 mL 2 x 40mg/0.4 mL	Pens	0 _____
❑ **Ilumya (tildrakizumab-asmn)**	❑ Inject 100mg subq at week 0,4 and every 12 weeks thereafter	1 x 100mg/ml	PFS	_____
❑ **Orencia® (abatacept)** *Psoriatic Arthritis*	❑ Infuse ____ mg IV at week 0 and 2	_____ x 250 mg/mL	Vials	0
	❑ Infuse ____ mg IV at week 4 and every 4 weeks thereafter	_____ x 250 mg/mL	Vials	_____
	< 60 kg = 500 mg, 60 to 100 kg = 750 mg, > 100 kg = 1000 mg			
	❑ Inject 125 mg subcut once weekly	4 x 125 mg/mL	❑ PFS ❑ ClickJect™ Autoinjector	_____
❑ **Otezla® (apremilast)**	❑ Take as directed per package instructions	55 tablets	28-day starter pack	0
	❑ Take 30 mg by mouth twice daily	60 x 30 mg	Tablets	_____

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

Injection Training Provided by: ❑Physician's Office ❑ CoxHealth at Home Specialty Pharmacy ❑ 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: _____

I authorize CoxHealth at Home. 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 CoxHealth at Home.