# CoxHealth at Home

# Dermatology (drugs T-Z)

**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 |
|---|---|---|---|
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| | | | |

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

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

| Prescription | | Quantity | | Refill |
|---|---|---|---|---|
| | Medications starting A-S are on their respective enrollment forms | | | |
| **Taltz® (Ixekizumab)** | ❑ Weeks 0 - 2: Inject 160 mg (2 x 80 mg) subq at week 0, then inject 80 mg subq at week 2 | 3 x 80 mg/mL | ❑ Autoinjectors ❑ PFS | 0 |
| | Weeks 4 - 10: Inject 80 mg subq at week 4 and every two weeks thereafter through week 10 | 2 x 80 mg/mL | ❑ Autoinjectors ❑ PFS | 1 |
| | ❑ Week 12 onwards: Inject 80 mg subq at week 12 and every four weeks thereafter | 1 x 80 mg/mL | ❑ Autoinjectors ❑ PFS | _____ |
| Tremfya™ **(guselkumab)** | ❑ Inject 100 mg subq at week 0 | 1 x 100 mg/mL | PFS | 0 |
| | Inject 100 mg subq at week 4 and every 8 weeks thereafter | 1 x 100 mg/mL | PFS | _____ |
| | ❑ Inject 100 mg subq every 8 weeks | 1 x 100 mg/mL | PFS | _____ |
| ❑ **Xeljanz (tofacitinib)** | Take 5 mg by mouth twice daily | 60 x 5mg | Tablets | _____ |
| ❑ **Xeljanz XR (tofacitinib)** | Take 11 mg by mouth daily | 30 x 10mg | Tablets | _____ |
| | | | | |

Injection Training Provided by: ❑ Physician's Office ❑ CoxHealth at Home ❑ 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.