For assistance, contact your pharmacy representative: ______________________ Phone: ______________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens Pharmacy

Dermatology
Prescription/Pharmacy Intake Form

Pharmacy: ______________________

Pharmacy Fax: ______________________ Pharmacy Phone: ______________________

Date Needed: ____________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ______________________

PATIENT INFORMATION

Patient name: ______________________ DOB: ____________ ☐Male ☐Female

Address: ______________________ City: ____________ State: ________ Zip code: ____________

Phone # (Daytime): ______________________ Phone # (Evening): ______________________

E-mail Address: ______________________

Insurance provider **(Please include copy of front and back of card)**: ______________________

ID #: ____________ Policy/Group #: ____________ Phone #: ____________ ☐Patient is eligible for Medicare

Name of Insured: ______________________ Employer: ______________________

Relationship to Patient: ☐Self ☐Other: ____________ Prescription Card: ☐Yes ☐No Carrier: ____________ Policy/Group #: ____________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy Start date: ____________

Primary Diagnosis Code and Condition (ICD-10): ______________________ Date of Diagnosis/Years with Disease: ____________

_______% BSA affected by Psoriasis Severity: ☐Moderate ☐Moderate to Severe ☐Severe Number of tender/swollen joints: ________ TB Test Result: ____________ Date: ________

☐Inadequate Response to Standard Systemic Agents ☐Inadequate Response to Standard Phototherapy Current Weight: ____________ Date: ________

Allergies: ______________________

MEDICATIONS

Adbry (tralokinumab-ldrm)
☐150mg 2 cartons (4 prefilled syringes)
☐150mg 1 carton (2 prefilled syringes)
Qty: _______ Refills: ________
Directions: ______________________

Cibinqo (abrocitinib)
☐50mg Tablets ☐100mg Tablets ☐200mg Tablets
Qty: _______ Refills: ________
Directions: ______________________

Cimzia (certolizumab pegol)
☐Starter Kit 6x200mg Prefilled Syringes
Qty: _______ Refills: ________
Directions: ______________________
☐2x200mg Vials ☐2x200mg Prefilled Syringes
Qty: _______ Refills: ________
Directions: ______________________

Cosentyx (secukinumab)
☐150mg Pen
☐150mg Prefilled Syringe
☐2X150mg Pack (300mg) Pen
☐2X150mg Pack (300mg) Prefilled Syringe
Qty: _______ Refills: ________
Directions: ______________________

Dupixent (dupilumab)
☐200mg Prefilled Syringe with Needle Shield
☐300mg Prefilled Syringe with Needle Shield
☐200mg Pen
☐300mg Pen
Qty: _______ Refills: ________
Directions: ______________________

Enbrel (entanercept)
☐25mg Prefilled Syringe
☐25mg Vial
☐50mg Prefilled Syringe
☐50mg SureClick™ Pen
☐50mg Mini™ Cartridge
Qty: _______ Refills: ________
Directions: ______________________

Humira (adalimumab)
☐4x40mg Pens – Psoriasis Starter Kit
☐6x40mg Pens – Hidradenitis Suppurativa Starter Kit
Qty: _______ Refills: ________
Directions: ______________________

Humira (adalimumab)
☐40mg/0.8ml Prefilled Syringes ☐40mg/0.8ml Pens
☐Other: ______________________
Qty: ________ Refills: ________
Directions: ______________________

Humira citrate free (adalimumab)
☐80mg/0.8ml & 40mg/0.4ml Psoriasis citrate free Starter Kit
☐80mg/0.8ml – Hidradenitis suppurativa citrate free Starter Kit
Qty: ________ Refills: ________
Directions: ______________________
☐40mg/0.4ml citrate free Prefilled Syringes
☐40mg/0.4ml citrate free Pens
☐80mg/0.8ml citrate free Pens
Qty: ________ Refills: ________
Directions: ______________________

Ilumya (tildrakizumab-asmn)
☐100mg/ml Prefilled Syringe
Qty: ________ Refills: ________
Directions: ______________________

Inflectra (infliximab-dyyb)
☐100mg Vial
Qty: ________ Refills: ________
Directions: ______________________

Olumiant (baricitinib)
☐2mg Tablets ☐4mg Tablets
Qty: ________ Refills: ________
Directions: ______________________

Orencia (abatacept)
☐250mg Vial ☐125mg Prefilled Syringe ☐125mg Clickjet Pen
Qty: ________ Refills: ________
Directions: ______________________

Otezla (apremilast)
☐Titration Pack
Qty: ________ Refills: ________
Directions: ______________________
☐30mg Tablets
Qty: ________ Refills: ________
Directions: ______________________

Remicade (infliximab)
☐100mg Vial
Qty: ________ Refills: ________
Directions: ______________________

Renflexis (infliximab-abda)
☐100mg Vial
Qty: ________ Refills: ________
Directions: ______________________

Rinvoq (upadacitinib)
☐15mg Tablets ☐30mg Tablets
Qty: _______ Refills: ________
Directions: ______________________

Siliq (brodalumab)
☐210mg Prefilled Syringe
Qty: _______ Refills: ________
Directions: ______________________

Simponi (golimumab)
☐50mg SmartJect™ AutoInjector ☐50mg Prefilled Syringe
Qty: _______ Refills: ________
Directions: ______________________

Simponi Aria (golimumab)
☐50mg Vial
Qty: _______ Refills: ________
Directions: ______________________

Skyrizi (risankizumab-rzaa)
☐150mg Pen ☐150mg Prefilled Syringe
Qty: _______ Refills: ________
Directions: ______________________

Stelara (ustekinumab)
☐45mg Prefilled Syringe ☐45mg Single-dose Vial
☐90mg Prefilled Syringe
Qty: _______ Refills: ________
Directions: ______________________

Taltz (ixekizumab)
☐80mg Prefilled Syringe ☐80mg AutoInjector
Qty: _______ Refills: ________
Directions: ______________________

Tremfya (guselkumab)
☐100mg/ml One-Press Patient-Controlled Injector
☐100mg/ml Prefilled Syringe
Qty: _______ Refills: ________
Directions: ______________________

Xeljanz
☐5mg Tablets ☐11mg XR Tablets
Qty: _______ Refills: ________
Directions: ______________________

☐**Other:** ______________________
Qty: _______ Refills: ________
Directions: ______________________

Methotrexate – Can only be ordered with other specialty meds. ☐2.5mg Tablet Directions: ______________________ Qty: ________ Refills: ________

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________

Address: ______________________ City: ____________ State: ________ Zip code: ____________

Office contact: ______________________ Phone: ____________ Fax: ____________

Email: ______________________ Best time to call: ____________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: ____________ DEA #: ____________ NPI #: ____________ Medicaid UPIN #: ____________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

______________________ Dispense as written

______________________ Substitution permitted

____________ Date

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.** The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

©2022 AllianceRx Walgreens Pharmacy All rights reserved. 082422