Star Discount Pharmacy specialty care

Psoriasis

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name: ___________________________ DOB: __________ Gender: ○M ○F
Address: __________________________ City: ______________ State: ____ Zip: ________ Phone: ___________________ Alt. Phone: __________________
Email:____________________ Ht:____ Wt:____ Care Giver: _____________________ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: _____________________________ Address: ___________________________City: ________________ State: ______
Zip: _________ NPI: _____________________ Phone: ____________ Fax: ____________ Office Contact: ________________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: ___________ ICD-10: _____________ Other: ______________ TB Test: ○Positive ○Negative Date: _____________
LFT: ALT: ________ AST: _________ Date: ______________ Assessment: ○ Moderate ○Mod to Severe ○Severe ____% BSA Affected
○Scalp ○Face ○Chest ○Arms ○Hands ○Nails ○Back ○Groin ○Buttocks ○Legs ○Other ____________

Patient also taking methotrexate? ○**Yes** ○**No**
Serious or active infection present? ○**Yes** ○**No**
Hep B ruled out or treatment started? ○**Yes** ○**No**
Does patient have latex allergy? ○**Yes** ○**No**

Injection Training: ○Pharmacist to Provide Training
○To be Administered by a Healthcare Provider
○Patient Trained in MD Office ○Manufacturer Nurse Support

Prior Failed Treatments	Length of Treatment
○Topicals	
○Methotrexate	
○Oral Meds	
○Biologics	
○UVA ○UVB	
○Others	

Product Delivery: ○Patient's Home ○Physician's Office ○Pharmacy to Coordinate

Prescription Information

Medication	Dosage & Strength	Direction	Qty	Ref
○Cimzia	○200mg/ml Prefilled Syringe	○Inject 400mg SC every other week		
	○200mg Lyophilized Powder Vial	○**Induction Dose:** (Weight <90kg) Inject 400mg SC every other week initially and at weeks 2 and 4		
		○**Maintenance Dose:** (Weight <90kg) Inject 200mg SC every other week		
○Cosentyx	○150mg/ml Sensoready Pen ○150mg/ml Prefilled Syringe ○150mg/ml Lyophilized Powder Vial	○**Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
		○**Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
		○**Maintenance Dose:** Inject 150mg SC every four weeks	1	
		○**Maintenance Dose:** Inject 300mg SC every four weeks	2	
○Enbrel	○50mg/ml Sureclick Autoinjector	○**Induction Dose:** Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
	○50mg/ml Prefilled Syringe ○25mg Lyophilized Powder Multiple Dose Vial ○Other: ___________________________	○**Maintenance:** Inject 50mg SC once a week **Pediatric Patients:** To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder	4	
		○> 138lbs or more: Inject 50mg weekly	4	
		○< 138lbs: Inject 0.8mg/kg weekly		
		○Other: ____________________________________		
○Humira	○Psoriasis Starter Package ○80mg/0.8ml Pen	○**Induction Dose:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	3	0
	○40mg/0.4ml Pen ○40mg/0.4ml Prefilled Syringe ○40mg/0.8ml Pen ○40mg/0.8ml Prefilled Syringe	○**Maintenance:** Inject 40mg SC every other week ○Other: ____________________________________	2	
	○Hidradenitis Suppurativa Starter Package 80mg/0.8ml Pen	○**Induction Dose:** ○Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ○Inject one 80mg pen SC on day 1, one 80mg pen on day 2, then one 80mg pen on day 15	3	0
	○40mg/0.4ml Pen ○40mg/0.4ml Prefilled Syringe ○40mg/0.8ml Pen ○40mg/0.8ml Prefilled Syringe	○**Maintenance:** Inject 40mg SC on day 29 and every week thereafter *Patient has signed HUMIRA Complete form*	4	
○Orencia	○125mg/ml ClickJectTM Autoinjector ○125mg/ml Prefilled Syringe	○Inject 125mg SC once a week	4	
○Otezla	○Starter Pack (Titration)	○**Starter Pack:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack	1	0
	○30mg Tablets	○**Maintenance:** Take one 30mg tablet by mouth twice daily	60	
○________	○_____________________________	○_______________________________________		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ________________________ Signature:______________________ Date: ______________
Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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ACHC

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Prescription Information

Medication	Dosage & Strength	Direction	Qty	Ref
○Rasuvo	○	○		
○Siliq	○210mg/1.5ml Prefilled Syringe	○**Induction Dose:** Inject 210mg subcutaneously at weeks 0,1, and 2 ○**Maintenance Dose:** Inject 210mg subcutaneously every 2 weeks	○1Mth ○2Mths ○3Mths	
○Simponi	○50mg/0.5ml Smartject Injector ○50mg/0.5ml Prefilled Syringe	○Inject 50mg SC once a month	1	
○Skyrizi	○75mg/0.83ml Prefilled Syringe	○**Induction Dose:** Inject 150mg (two 75mg injections) SC at wks 0 and 4 ○**Maintenance Dose:** Inject 150mg (two 75mg injections) SC every 12 weeks thereafter	4	0
	○**Skyrizi Self-Injection**: *Healthcare provider certifies that patient has been trained and is eligible for self-injection*		2	
○Stelara	○45mg/ml Single-Dose Vial	**Induction Dose: To achieve pediatric dose**		
		○< 60kg: Inject 0.75mg/kg		0
		○60kg-100kg: Inject 45mg/kg	1	0
		○>100kg: Inject 90mg/kg	1	0
	○45mg/ml Prefilled Syringe (for <220lb)	○Inject the contents of 1 Prefilled Syringe SC on day 1		
	○90mg/1ml Prefilled Syringe (for >220lb) ○**Stelara Self-Injection:** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*	**Maintenance Dose**: ○Inject the contents of 1 Prefilled Syringe SC on day 29 and every 12 weeks thereafter	1	
○Taltz	○80mg/ml Single-Dose Prefilled Autoinjector 80mg/ml Single-Dose Prefilled Syringe	○**Weeks 0-2:** Inject 160mg (two 80mg injections) at week 0, then inject 80mg SC at week 2	3	0
		○**Weeks 4-10:** Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	2	1
		○**Week 12 and onward:** Inject 80mg SC at week 12 and every 4 weeks thereafter	1	
○Tremfya	○100mg/ml Prefilled Syringe ○100mg/ml One-Press Patient Controlled Injector	○**Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4	2	
		○**Maintenance:** Inject 100mg/ml SC every 8 weeks thereafter	1	
○Xeljanz	○5mg Tablet	○Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
○Xeljanz XR	○11mg Tablet	○Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	
○	○	○		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ________________________________ Signature________________________________ Date: ______________

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