Star Discount Pharmacy specialty care

Psoriasis

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name: _____ DOB: _____ Gender: ○M ○F Last 4 of SSN:
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
○ 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	1Month 2Months 3Months	
○ Simponi	○ 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe	Inject 50mg SC once a month	1	
○ Skyrizi	○ 150mg/ml Prefilled Syringe ○ 150mg/ml Auto Injector Skyrizi Self-Injection: *Healthcare provider certifies that patient has been trained and is eligible for self-injection*	○ **Induction Dose:** Inject 150mg SC at weeks 0 and 4 ○ **Maintenance Dose:** Inject 150mg SC every 12 weeks thereafter	2 1	0
○ Stelara	○ 45mg/0.5ml Prefilled Syringe (for <220lb)	○ 60kg-100kg:Inject 45mg/SC ○ >100kg: Inject 90mg/SC		
	○ 90mg/ml Prefilled Syringe (for >220lb)	○ Inject the contents of 1 Prefilled Syringe SC on day 1	1 1	0 0
	○ 90mg/1ml Prefilled Syringe (for >220lb) ○ Yes ○ No Stelara Self-Injection: *Healthcare provider has certified 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 ○ **Weeks 4-10:** Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10 ○ **Week 12 and onward:** Inject 80mg SC at week 12 and every 4 weeks thereafter	3 2 1	0 1
○ Tremfya	○ 100mg/ml Prefilled Syringe ○ 100mg/ml One-Press Patient Controlled Injector	○ **Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4 ○ **Maintenance:** Inject 100mg/ml SC every 8 weeks thereafter	2 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: _____

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.