VERBAL ORDER FORM
DERMATOLOGY

QuickRX SPECIALTY PHARMACY

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Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ QuickRX Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code ☐ **L40.59** Psoriatic Arthritis ☐ **L40.0** Psoriasis ☐ **L20.___** Atopic Dermatitis ☐ **M35.2** Behçet's Disease ☐ Other_____
PPD (TB Test)? ☐ Yes ☐ No Date_____ Does patient have latex allergy (for Enbrel)? ☐ Yes ☐ No
_____% BSA (body surface area) affected by Psoriasis Weight _____ lb or _____Kg
Methotrexate contraindicated: Due to social activities? ☐ Yes ☐ No Because patient is of child bearing age? ☐ Yes ☐ No
Previously treated for this condition? ☐ Yes ☐ No Please indicate failed medication(s) below

	Medication	Strength	Duration of Treatment/ Reason for Discontinuation		Medication	Strength	Duration of Treatment/ Reason for Discontinuation
Biologics				Oral Meds			
Topical Meds				Phototherapy			

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

CIMZIA® 200mg/mL ☐ PFS 2-ct ☐ PFS 6-ct Starter Kit
Psoriasis: ☐ Standard Dose: Inject 400mg SQ every other week QTY: 2 PFS Refill:_____
Less than 90kg, may consider: ☐ Starter: Inject 400mg SQ at weeks 0, 2, and 4 QTY: 6 PFS Refill: 0
☐ Maintenance: Inject 200mg SQ every other week thereafter QTY: 2 Refill:_____
Psoriatic Arthritis ☐ Starter: Inject 400mg SQ at week 0, 2, and 4 QTY: 6 PFS Refill: 0
☐ Maintenance: Inject 200mg SQ every other week QTY: 2 Refill:_____
☐ Maintenance: Inject 400mg SQ every four weeks QTY: 2 Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *CIMplicity*

COSENTYX® ☐ 150 mg Sensoready® Pen ☐ 150 mg Prefilled Syringe
☐ **Starting Dose:** Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
☐ Inject 300 mg dose SQ once weekly for 5 weeks *(Each 300 mg dose is given as 2 SQ injections of 150 mg)*
QTY: 10 injection devices Refills: 0
☐ Inject 150 mg dose once weekly for 5 weeks QTY: 5 injection devices Refill: 0
☐ **Maintenance Supply:** Once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ once every 4 weeks *(Each 300 mg dose is given as 2 SQ injections of 150 mg)*
☐ Inject 150 mg dose SQ once every 4 weeks
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *Cosentyx® Connect*

DUPIXENT® ☐ 300mg/mL PFS ☐ 200mg/1.14mL PFS *ATOPIC DERMATITIS*
Adolescents:
☐ (<60kg) **Starter:** Inject 400mg SQ on Day 1, then inject 200mg SQ every other wk. QTY: 4 PFS Refill: 0
☐ **Maintenance:** Inject 200mg SQ every other week. QTY: 2 PFS Refill:_____
☐ (≥ 60kg) **Starter:** Inject 600mg SQ on Day 1, then inject 300mg SQ every other wk. QTY: 4 PFS Refill: 0
☐ **Maintenance:** Inject 300mg SQ every other week. QTY: 2 PFS Refill:_____
Adults:
☐ **Starter:** Inject 600mg SQ on Day 1, then inject 300mg SQ every other week. QTY: 4 PFS Refill: 0
☐ **Maintenance:** Inject 300mg SQ every other week. QTY: 2 PFS Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *MyWay™*

ENBREL® (etanercept) ☐ SureClick™ Autoinjector 50mg ☐ Prefilled Syringe 50mg
☐ Enbrel Mini™/AutoTouch 50mg ☐ Multiuse Vial 25mg ☐ Prefilled Syringe 25mg/0.5ml
Dispense: ☐ **Psoriasis Induction Dose:** Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing QTY: 8 Refills: 2
☐ **Psoriasis Maintenance Dose:** Inject 50mg SC ONCE a week QTY:_____ Refill:_____
☐ **Psoriatic Arthritis Dose:** Inject 50mg SC ONCE a week QTY:_____ Refill:_____
☐ Other: _____ QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *ENBREL Support™*

HUMIRA® and HUMIRA Citrate-Free® *Patient weight (kg)*_____
Adult Psoriasis/Adolescent HS (30kg to <60kg) Starter:
☐ 80mg/0.8ml + 40mg/0.4ml citrate-free Pen Starter Kit (3-ct)
☐ 40mg/0.8ml Pen Original Starter Kit (4-ct)
SIG: Inject 80mg SQ on Day 1, then inject 40mg SQ on Day 8, then inject 40mg SQ every other week. QTY: 1 Kit Refill: 0
Adult HS Starter: ☐ 80mg/0.8ml Citrate-free Pen Hidradenitis Suppurativa Starter Kit (3-ct)
☐ 40mg/0.8ml Pen Hidradenitis Suppurativa Starter Kit (6-ct)
SIG: Inject 160mg SQ on Day 1, then inject 80mg SQ on Day 15. QTY: 1 Kit Refill: 0
Maintenance: ☐ 40mg/0.4ml citrate-free Pen (2-ct) ☐ 40mg/0.4ml citrate-free PFS (2-ct)
☐ 40mg/0.8ml Pen (2-ct) ☐ 40mg/0.8ml PFS (2-ct)
☐ **Adult Psoriasis/Adolescent HS Sig:** Inject 40mg SQ every other week.
☐ **Adult Hidradenitis Suppurativa Sig:** Inject 40mg SQ every week starting on Day 29.
☐ **Other:** _____ QTY: ____ Refill:____
☐ Sharps Container ☐ If applicable, enroll patient in *Ambassador Program*

ILUMYA™ ☐ Prefilled Syringe 100mg/mL
☐ **Starting Dose:** Initial dose of 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 12 weeks thereafter QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *ILUMYA SUPPORT™*

OTEZLA® ☐ Prescriber provided Two-Week Starter Pack on _____
Starter: ☐ 28 Day Starter Pack SIG: Take as directed QTY: 55 Refill: 0
☐ 30mg twice daily (recommended) ☐ 30mg daily (for severe renal impairment)
Maintenance: ☐ SIG: Take one tablet by mouth twice daily QTY: 60 Refill:_____
☐ SIG: Take one tablet by mouth daily QTY: 30 Refill:_____
☐ If applicable, enroll in *Otezla SupportPlus™* ☐ If applicable, enroll in *Bridge RX Program*

RASUVO® ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg
☐ Inject ____mg subcutaneously weekly QTY: 4 Refill:_____ ☐ If applicable, enroll in *CORE Connections*

REMICADE® ☐ 100mg Vial QTY:_____# of vials Refill:_____
☐ **Induction Dose:** Infuse 5mg/kg in 250mL of 0.9% NaCl at wk 0,wk 2, wk 6, & every 8 wks thereafter
☐ **Maintenance Dose:** Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 weeks
☐ Other: _____
☐ If applicable, enroll patient in *Janssen CarePath*

SILIQ™ ☐ 210 mg/1.5 mL PFS
☐ **Induction Dose:** Inject 210 mg of SILIQ at Weeks 0, 1, and 2 then maintenance QTY: 3 Refill:_____
☐ **Maintenance Dose:** Inject 210 mg of SILIQ every 2 weeks QTY: 2 Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *Siliq Solutions™*

SIMPONI™ ☐ SmartJect™ Autoinjector ☐ PFS 50mg/0.5mL
☐ **Psoriatic Arthritis Dose:** Inject 50 mg (0.5ml) SQ once a month QTY: 1 vial Refill:_____
☐ Other: _____ QTY:_____ Refill:_____
SIMPONI ARIA™ ☐ 50mg/4ml (12.5mg/ml) in a single use vial
☐ **Dose:** 2mg/kg intravenous infusion over 30 minutes at wks 0 & 4, then every 8 wks QTY: 1 vial Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *SimponiOne®*

SKYRIZI® 75 mg/0.83 mL PFS *PLAQUE PSORIASIS*
☐ **Start Dose:** Inject 150mg (two 75 mg injections) SQ at week 0, week 4 QTY: 4 Refill: 0
☐ **Maintenance:** Inject 150mg (two 75 mg injections) SQ every 12 wks thereafter QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *Skyrizi Complete*

STELARA™ ☐ **45mg/0.5mL PFS** ☐ **90mg/mL PFS** *Patient Weight (kg):*_____
Starting Dose: ☐ Inject 45mg (1 PFS) SQ for patients weighing <100kg (220lbs) initially and then 4 weeks later QTY: 1 PFS Refills: 0
Maintenance Dose: ☐ Inject 45mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refill:_____
Starting Dose: ☐ Inject 90mg (1 PFS) SQ for patients weighing >100kg (220lbs) initially and then 4 weeks later QTY: 1 PFS Refills: 0
Maintenance Dose: ☐ Inject 90mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refill:_____
☐ Other: _____ QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *Janssen CarePath*

TALTZ® 80mg ☐ Autoinjector ☐ Prefilled Syringe
☐ **Starting Dose:** Inject 160mg SQ at wk 0 followed by 80mg at wks 2,4,6,8,10 & 12 QTY: 8 Refills: 0
☐ **Maintenance Dose:** Inject 80mg SQ every 4 weeks QTY:_____ Refill:_____
☐ Other: _____ QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *Taltz Together™*

TREMFYA™ ☐ Prefilled Syringe 100mg/mL ☐ One-Press Injector 100mg/mL
☐ **Starting Dose:** Initial dose of 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 8 weeks thereafter. QTY:_____ Refill:_____
☐ Sharps Container ☐ If applicable, enroll patient in *Janssen CarePath*

OTHER MEDICATION_____
SIG:_____ **QTY:**_____ **REFILL:**_____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

By signing this form and utilizing our services, you are authorizing QuickRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed referral form to **QuickRx** at **347-691-3496**
Visit us at **quickrxspecialty.com** for online fillable forms.