Wellness Pharmacy
AND COMPOUNDING CENTER
2601 Blue Ridge Rd,
Raleigh, NC 27607
P. 919.964.5656 / F. 919.964.5757

Dermatology (A-K)

Date: _____ Date needed: _____ Ship to: □ Patient □ 1st dose to MD □ All dose to MD

Prescriber information

Prescriber:	NPI:
Supervising physician:	NPI:
Address:	Tax ID:
Phone:	Fax:
Office contact:	

Patient information

Name:	Sex: ☐ M ☐ F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight:	Height:	Allergies:	Latex Allergy: Y N
Primary language: ☐ English ☐ Spanish ☐ Other:	Needs interpreter: ☐ Yes ☐ No		

Please include copies of the patient's insurance card & chart notes if applicable.

Medical information

Primary diagnosis:	ICD-10:	Date of diagnosis:	TB Test Completed On:	Result: Pos Neg

Previous therapies:	Duration:	Outcome:
BSA/Scoring Tool:	Injection Training: Office ☐ Pharmacy to arrange ☐	Saving Enrollment: Office ☐ Pharmacy ☐

Prescription information

Drug	Strength	Directions	Qty	Refills
☐ Cimzia®	☐ 200 mg prefilled syringe	**Initial:** ☐ Inject 400 mg subcutaneously at weeks 0, 2, and 4 **Maintenance:** ☐ Inject 200 mg subcutaneously once every 14 days ☐ 400 mg subcutaneously once every 14 days	1 starter kit 4 week supply	0
☐ Cosentyx®	☐ SensorReady Pen ☐ Prefilled syringe	**Initial**: ☐ Inject 150 mg subcutaneously on week 0, 1, 2, 3, and 4 **Maintenance:** ☐ Inject 150 mg subcutaneously every 4 weeks **Initial**: ☐ Inject 300 mg subcutaneously on week 0, 1, 2, 3, and 4 **Maintenance:** ☐ Inject 300 mg subcutaneously every 4 weeks	5 1 10 2	0 ____ 0 ____
☐ Dupixent®	☐ 300 mg/2 ml Syringe	**Initial:** ☐ Inject 600 mg subcutaneously on day 1, then starting day 15 inject 300 mg subcutaneously every other week **Maintenance:** ☐ Inject 300 mg subcutaneously every other week	2 2	1 ____
☐ Enbrel®	☐ 25 mg prefilled syringe ☐ 50 mg prefilled syringe ☐ 50 mg SureClick™ ☐ 50 mg Mini®	**Initial:** ☐ Inject 50 mg subcutaneously twice a week 72 to 96 hours apart **Maintenance:** ☐ Inject 25 mg subcutaneously once weekly **Maintenance:** ☐ Inject 50 mg subcutaneously once weekly	4 week supply	____ ____ ____
☐ Humira® (Psoriasis)	☐ 40 mg/0.8 ml PFS ☐ 40 mg/0.8ml PENS ☐ 40 mg/0.4 ml CF PEN	**Initial:** ☐ Inject 80 mg subcutaneously on day 1, then 40 mg on day 8, then 40 mg every other week starting day 22 **Maintenance:** ☐ Inject 40 mg subcutaneously every other week	4 2	0 ____
☐ Humira® (Hidradenitis Suppurativa)	☐ 40 mg/0.8 ml PFS ☐ 40 mg/0.8ml PEN ☐ 40 mg/0.4 ml CF PEN	**Initial:** ☐ Inject 160 mg subcutaneously on day 1, then 80 mg on day 15, then 40 mg every week starting day 29 **Maintenance:** ☐ Inject 40 mg subcutaneously every week	6 4	0 ____
☐ Ilumya™	☐ 100 mg prefilled syringe	**Initial:** ☐ Inject 100 mg subcutaneously at week 0 and week 4 **Maintenance:** ☐ Inject 100 mg subcutaneously every 12 weeks	1 1	1 ____
☐ Other	_____	_____		_____
☐ Prescriber authorizes dispensing of ancillary kits and supplies as necessary/applicable		As needed for administration		

By signing below I authorize Wellness Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

Stamp signature not allowed, physician attests this is his/her legal signature.

_____ _____ _____ _____

Dispense as Written / Brand Medically Necessary **Date** **Substitution allowed** **Date**