Wellness Pharmacy AND COMPOUNDING CENTER

2601 Blue Ridge Rd,
Raleigh, NC 27607
P. 919.964.5656 / F. 919.964.5757

Dermatology (L-Z)

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
☐ Otezla®	☐ Starter pack ☐ 30 mg tablets	☐ **Starter pack:** Take as directed per package instructions ☐ **Maintenance:** Take one tablet by mouth once daily ☐ **Maintenance:** Take one tablet by mouth twice daily	1 pack 30 60	0 _____ _____
☐ Siliq™	210 mg pre-filled syringe	**Initial**: ☐ Inject 210 mg subcutaneously on weeks 0, 1, 2, then begin maintenance dose starting week 4 **Maintenance:** ☐ Inject 210 mg subcutaneously every two weeks	4 2	0 _____
☐ Skyrizi™	Please use form available from the manufacturer's website and send to Josefs Pharmacy			
☐ Stelara®	☐ 45 mg prefilled syringe (Weight < 220 lbs) ☐ 90 mg prefilled syringe (Weight ≥ 220 lbs)	**Initial:** ☐ Inject 45 mg subcutaneously on day 0, then week 4, then every 12 weeks **Maintenance:** ☐ Inject 45 mg subcutaneously every 12 weeks **Initial:** ☐ Inject 90 mg subcutaneously on day 0, then week 4, then every 12 weeks **Maintenance:** ☐ Inject 90 mg subcutaneously every 12 weeks	1 1 1 1	2 _____ 2 _____
☐ Tremfya™	☐ 100 mg/ml prefilled syringe ☐ 100 mg/ml auto injector	**Initial:** ☐ Inject 100 mg subcutaneously at week 0 and week 4 **Maintenance:** ☐ Inject 100 mg subcutaneously every 8 weeks	1 1	1 _____
☐ Taltz® (Psoriasis)	☐ 80 mg/ml prefilled syringe ☐ 80 mg/ml auto injector	**Initial:** ☐ Inject 160 mg subcutaneously at week 0 **Induction:** ☐ Inject 80 mg subcutaneously every two weeks (weeks 2, 4, 6, 8, 10, and 12) **Maintenance:** ☐ Inject 80 mg subcutaneously every 4 weeks	1 2 1	0 3 _____
☐ 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**