Ochsner® Specialty Pharmacy

Dermatology

1405 Jefferson Hwy Suite A
New Orleans, LA 70121
Phone: (504) 842-7439
1-855-312-4193
Fax: (504) 842-5999

PATIENT INFORMATION:

Patient Name:___________________________________
Date of Birth:____________Male: ☐ Female: ☐
Address:______________________________________
City/State/Zip:_________________________________
Tel:___________________Alt Tel:_________________
SS#:___________________Wt:_________Ht:_________

NKDA: ☐ Allergy:____________________________

INSURANCE INFORMATION:

Primary Pharmacy Insurance_______________________
Member Name:_________________________________
Member ID:___________________________________
Rx Group #:___________________________________
BIN#________________PCN#____________________
Customer Service #:_____________________________
Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis: ☐ L40.50 Psoriatic Arthritis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L73.2 Hidradenitis Suppurativa
☐ Other:____

Prior Med Failed: ________________ Length of Treatment:____________Reason for D/C:________________________
________________ Length of Treatment:____________Reason for D/C:________________________
________________ Length of Treatment:____________Reason for D/C:________________________

Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other:_______________________%BSA___________
TB/PPD test: ☐ ☐ Pos Neg Date Read: ☐___________ Does patient have a latex allergy? Yes No

PRESCRIBER INFORMATION:

Prescriber Name:______________________________________Specialty:_________________________________
Address:____City/State/Zip:_____________________________
Contact Name:___________________Phone #:___________________________Fax #:_______________________
DATE:___________________NPI#:_________________________DEA #:__________________UPIN #:______________

By signing this form and using our services, you are authorizing Ochsner Specialty Pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies. Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

____ *Substitution Allowed*

____ *Dispense as Written*

PRESCRIPTION:

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	________
☐ Cosentyx®	☐ 150mg/ml Sensoready® ☐ 150mg/ml PFS ☐ 150mg lypholized powder	☐ Load: Inject 300mg or 150mg subcutaneously week 0,1,2,3,4 ☐ Maintenance: Inject: 300mg or 150mg subcutaneously every 4 weeks	1 month supply	________
☐ Enbrel®	☐ 50mg Sureclick ☐ 50mg PFS ☐ 25mg Vials ☐ 25mg PFS	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly 72-96 hours apart ☐ Inject 25mg twice weekly 72-96 hours apart	1 month supply	________
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SubQ once a week ☐ Inject 40mg SubQ every other week ☐ Inject 80mg day 1, then 40mg day 8, then 40mg every other week	1 month supply	________
☐ Odomzo	☐ 200mg capsule	☐ Take one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal	1 month supply	________
☐ Otezla®	☐ 30mg tablet ☐ Starter Pack	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily ☐ Starter Pack: Take 1 tablet by mouth day 1, then take 1 tablet by mouth twice daily as directed	1 month supply	________
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SubQ once monthly	1 month supply	________
☐ Stelara®	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45mg day 0 and week 4, then every 12 weeks (For patients ≤ 220 lbs) ☐ Inject 90mg day 0 and week 4, then every 12 weeks (for Patients > 220 lbs)	1 month supply	________
☐ OTHER	____________________	____	____________	________