Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Dermatology (A-C) Bimzelx®, Cibinqo™, Cimzia®, Cosentyx®

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10/Diagnosis Code ☐ Alopecia areata (L63) ☐ Psoriasis Vulgaris (L40.0) ☐ Other Psoriasis (L40.8)
☐ Psoriasis unspecified (L40.9) ☐ Psoriatic Arthritis (L40.5) ☐ Hidradenitis Suppurativa (L73.2)
☐ Chronic Urticaria (L50.8) ☐ Atopic Dermatitis (L20.9) ☐ Basal cell carcinoma (C44.___)
☐ Other _____

TB/PDD Test Given ☐ Y ☐ N Date of Neg. Test / /

HBV Positive? ☐ Y ☐ N If Yes, is patient currently treated? ☐ Y ☐ N

Prior Treatment? ☐ Y ☐ N (Provide Information Below) BSA Affected (%) _____

Affected Areas ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ Other _____

Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /
Approx. End Date / /

Comorbidities _____

Concomitant Medications _____

Community Memorial HEALTHCARE

Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **BIMZELX®** ☐ PFS ☐ Pen	☐ 1 carton (1x320 mg/2 mL) ☐ 2 cartons (2x320 mg/2 mL)	Starter Dose: ☐ Inject 320 mg SQ at weeks 0, 4, 8, 12 and 16 ☐ Inject 320 mg SQ at weeks 0, 2, 4, 6, 8, 10, 12, 14 and 16	4
	☐ 1 carton (1x320 mg/2 ml)	Maintenance Dose: ☐ Inject 320 mg SQ every 8 weeks ☐ Inject 320 mg SQ every 4 weeks	
☐ **CIBINQO™**	☐ 50 mg tablet (30 day supply) ☐ 100 mg tablet (30 day supply) ☐ 200 mg tablet (30 day supply)	☐ Take 1 tablet by mouth daily	
☐ **CIMZIA®** ☐ PFS	☐ 1 starter kit (6x200 mg/ml)	Starter Dose: ☐ Inject 400 mg SQ at weeks 0, 2 and 4	No Refills
	☐ 1 carton (2x200 mg/mL) ☐ 2 cartons (4x200 mg/mL)	Maintenance Dose: ☐ Inject 400 mg SQ every 4 weeks ☐ Inject 400 mg SQ every other week (plaque psoriasis only) ☐ Inject 200 mg SQ every other week	
☐ **COSENTYX®** *Pediatrics (age 6 & older)	☐ 4 cartons (4x75 mg/0.5 ml) PFS ☐ 4 cartons (4x150 mg/ml) PFS ☐ 4 cartons (4x150 mg/ml) PEN	Starter Dose: ☐ Weight < 50 kg: Inject 75 mg SQ at weeks 0, 1, 2 and 3 ☐ Weight ≥ 50 kg: Inject 150 mg SQ at weeks 0, 1, 2 and 3	No Refills
	☐ 1 carton (1x75 mg/0.5 ml) PFS ☐ 1 carton (1x150 mg/ml) PFS ☐ 1 carton (1x150 mg/ml) PEN	Maintenance Dose: ☐ Weight < 50 kg: Inject 75 mg SQ every 4 weeks beginning on Day 29 ☐ Weight ≥ 50 kg: Inject 150 mg SQ every 4 weeks beginning on Day 29	
☐ **COSENTYX®** *Adults ☐ PFS ☐ Sensoready® Pen/Unoready® Pen	☐ 4 cartons (4x300 mg/2 ml) ☐ 4 cartons (4x150 mg/mL) ☐ 8 cartons (8x150 mg/mL)	Starter Dose: ☐ Inject 300 mg SQ at weeks 0, 1, 2 and 3 ☐ Inject 150 mg SQ at weeks 0, 1, 2 and 3	No Refills
	☐ 1 carton (1x300 mg/2 ml) ☐ 1 carton (1x150 mg/mL) ☐ 2 cartons (2x150 mg/mL) ☐ 4 cartons (4x150 mg/mL)	Maintenance Dose: ☐ Inject 300 mg SQ every 4 weeks beginning on Day 29 ☐ Inject 300 mg SQ every 2 weeks beginning on Day 29 ☐ Inject 150 mg SQ every 4 weeks beginning on Day 29	

Community Memorial HEALTHCARE

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

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

Prescriber Signature _____
Substitution Permitted

Date _____

Prescriber Signature _____
Dispense as Written

Date _____

If brand is required, please write "DAW" in the box to the right. ☐