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

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Dermatology (R-S) Rinvoq™, Siliq®, Simponi®, Skyrizi™, Sotyktu™, Stelara®

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 _____

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **RINVOQ™** *Adults	☐ 15 mg tablet (30 tablets) ☐ 30 mg tablet (30 tablets)	☐ Take one tablet by mouth once daily	
☐ **RINVOQ™** *Pediatrics	☐ 1 mg/ml oral solution (quantity QS for 30 day supply in multiples of 180 ml) ☐ 15 mg tablet (30 day supply)	☐ Weight 10-19 kg: Take 3 mg (3 ml oral solution) by mouth two times daily ☐ Weight 20-29 kg: Take 4 mg (4 ml oral solution) by mouth two times daily Weight ≥ 30 kg: ☐ Take 6 mg (6 ml oral solution) by mouth twice daily ☐ Take 15 mg (one 15 mg tablet) by mouth once daily	
☐ **SILIQ®** *Product is limited to certified prescribers enrolled in Siliq REMS	☐ 2 cartons (4x210 mg/1.5 ml)	☐ Starter Dose: Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks after	No Refills
	☐ 1 carton (2x210 mg/1.5 ml)	☐ Maintenance Dose: Inject 210 mg SQ once every 2 weeks	
☐ **SIMPONI®** ☐ SmartJect® ☐ PFS	☐ 1 carton (1x50 mg/0.5 ml)	☐ Inject 50 mg SQ once a month	
☐ **SKYRIZI™** ☐ PFS ☐ Pen	☐ 1 carton (150 mg/mL)	☐ Starter Dose: Inject 150 mg SQ at weeks 0 and 4	1 Refill
	☐ 1 carton (150 mg/mL)	☐ Maintenance Dose: Inject 150 mg SQ every 12 weeks	
☐ **SOTYKTU™**	☐ 6 mg tablet (30 day supply)	☐ Take 1 tablet by mouth once daily	
☐ **STELARA®** *Adults Patient eligible for self-injection? ☐ Y ☐ N	☐ 1 carton (1x45 mg/0.5 ml) ☐ 1 carton (1x90 mg/mL)	☐ Starter Dose: Inject 45 mg SQ on Day 1 (≤100 kg) ☐ Starter Dose: Inject 90 mg SQ on Day 1 (>100 kg)	No Refills
		☐ Maintenance Dose: Inject 45 mg SQ once every 12 weeks beginning on Day 29 (≤100 kg) ☐ Maintenance Dose: Inject 90 mg SQ once every 12 weeks beginning on Day 29 (>100 kg)	

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **STELARA®** *Pediatrics	☐ 1 carton (1x45 mg/0.5 ml) PFS ☐ 1 carton (1x90 mg/mL) PFS	Starter Dose: ☐ Patients <60 kg: Inject 0.75 mg/kg SQ on day 1 ☐ Patients 60 kg-100 kg: Inject 45 mg SQ on day 1 ☐ Patients >100 kg: Inject 90 mg SQ on day 1	No Refills
	☐ 1 carton (1x45 mg/0.5 ml) PFS ☐ 1 carton (1x90 mg/mL) PFS	☐ Patients <60 kg: Inject 0.75 mg/kg SQ once every 12 weeks, starting on day 29 ☐ Patients 60 kg-100 kg: Inject 45 mg SQ once every 12 weeks, starting on day 29 ☐ Patients >100 kg: Inject 90 mg SQ once every 12 weeks, starting on day 29	

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. ☐