

## New/Changed Dose

## Dermatology (T-Z) Taltz®, Tremfya®, Xolair®

## 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** 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)

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 \_\_\_\_\_

**Prescription Information**

Medication	Quantity/Dose	Sig	Refills
<b>TALTZ®</b> (Plaque Psoriasis) Autoinjector PFS	3x80 mg/ml	Inject 160 mg SQ on Day 0 and 80 mg SQ at week 2	No Refills
	2x80 mg/ml	Titration Dose: Inject 80 mg SQ at weeks 4, 6, 8, 10	1 Refill
	1x80 mg/ml	Maintenance Dose: Inject 80 mg SQ every 4 weeks starting at week 12	
<b>TALTZ®</b> (Pediatric Plaque Psoriasis) PFS	<b>Pediatric</b> 2x80 mg/ml 1x80 mg/ml	<p>Starter Dose:            Patients &gt;50 kg: Inject 160 mg at week 0. Begin maintenance dosing at week 4</p> <p>Patients 25-50 kg: Inject 80 mg at week 0. Begin maintenance dosing at week 4.</p> <p>Patients &lt;25 kg: Inject 40 mg at week 0. Begin maintenance dosing at week 4.</p>	
	<b>Pediatric</b> 1x80 mg/ml	<p>Maintenance Dose:            Patients &gt;50 kg: Inject 80 mg every 4 weeks</p> <p>Patients 25-50 kg: Inject 40 mg every 4 weeks</p> <p>Patients &lt;25 kg: Inject 20 mg every 4 weeks.</p>	
	2x80 mg/ml	Starter Dose: Inject 160 mg SQ on Day 0	No Refills
	1x80 mg/ml	Maintenance Dose: Inject 80 mg SQ every 4 weeks starting at week 4	
<b>TREMIFYA®</b> PFS OnePress	2 cartons (2x100 mg/mL)	Starter Dose: Inject 100 mg SQ at weeks 0 and 4	No Refills
	1 carton (1x100 mg/mL)	Maintenance Dose: Inject 100 mg SQ every 8 weeks	
<b>XOLAIR®</b> PFS Pen	Number of 75 mg/0.5 ml pens/syringes _____ Number of 150 mg/ml pens/syringes _____ Number of 300 mg/2 ml pens/syringes _____	Inject 150 mg SQ every 4 weeks Inject 300 mg SQ every 4 weeks	



## 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 \_\_\_\_\_  
Date \_\_\_\_\_

Prescriber Signature \_\_\_\_\_  
Date \_\_\_\_\_

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