BURBANK SPECIALTY PHARMACY

Phone: 818-563-2120
Fax: 844-500-3843 or 818-563-2130

Patient Name:	Today's Date
DOB SSN	Prescriber:
Home Phone Work/Other Phone	Phone Number Fax Number
Home Address	Address
Shipping Address (If different from home address)	Office Contact: Prefers: ☐ Fax ☐ Phone ☐ E-Mail _____
Language Preference: ☐ English ☐ Spanish ☐ Other _____	Ship to: ☐ Home ☐ MDO NEED CLASS_____

Rx: ☐ HUMIRA Pen **or** ☐ HUMIRA Prefilled Syringe

TAPE PRESCRIPTION HERE PRIOR TO FAXING **OR** COMPLETE THE FOLLOWING:

Ankylosing Spondylitis:

Inject 40mg SQ every other week

Qty: _____ **Refill x** _____

Crohn Disease:

Starter Pack Dose:

☐ Inject 4 Pens (160mg) on Day 1 **then**

Inject 2 Pens (80mg) SQ 2 weeks after initial dose (on Day 15)

Maintenance Dose:

☐ Inject 40mg SQ every other week (starting on Day 29)

Qty: _____ **Refill x** _____

Hidradenitis Suppurativa (Mod-Severe):

Initial Dose:

☐ Inject 160mg (4 Pens) SQ on Day 1

then Inject 80mg (2 Pens) SQ 2 wks after initial dose (Day 15)

Maintenance Dose:

☐ Inject 40mg SQ every week (starting on Day 29)

Qty: _____ **Refill x** _____

Plaque Psoriasis (Chronic/Mod-Severe):

Initial Dose:

☐ Inject 2 Pens (80mg) SQ on Day 1, followed by

Inject 1 Pen (40mg) SQ every other week after initial dose

Qty: _____ **Refill x** _____

Psoriatic Arthritis

☐ Inject 40mg SQ every other week alone

Qty: _____ **Refill x** _____

Rheumatoid Arthritis (Mod-Severe):

☐ Inject 40mg SQ every other week

Qty: _____ **Refill x** _____

Ulcerative Colitis (Mod-Severe):

Initial Dose:

☐ Inject 160mg (4 Pens) SQ on Day 1 **then**

Inject 80mg (2 Pens) SQ 2 weeks after initial dose (Day 15)

Maintenance Dose:

☐ Inject 40mg SQ every other week (starting on Day 29)

Qty: _____ **Refill x** _____

Physician Signature: _____ **DEA**: _____