DERMATOLOGY PRESCRIPTION FORM (Part 2)

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.
Prescribers are reminded patients may choose any pharmacy of their choice.

Owl Specialty Pharmacy
1010 E. Arrow Hwy., Covina, CA 91724
Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523
www.owlspecialty.com

Patient Information: please provide a copy of the patient's insurance card or information					
Patient Name:	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**	
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**	
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**		
Allergies: ☐ NKDA ☐ List allergies:					

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10: ☐ Psoriasis /_____ ☐ Psoriatic Arthritis / _____ ☐ Chronic Idiopathic Urticaria / _____
☐ Hidradenitis Suppurativa / _____ ☐ Other: _____

PSO/PSA	**Diagnosed with:** ☐ CHF ☐ Latex Allergy ☐ MS ☐ Hep B/C ☐ Malignancy	**Affected areas:** ☐ palms ☐ soles ☐ head ☐ neck ☐ genitalia
	TB/PPD test: Y / N Date of negative test:	**% of BSA affected:**
	☐ **Patient is currently on therapy (Start date ___/____/_____)** **Prior Therapies:** Please include biologics, MTX, PUVA, topicals, UVB/NBUVB and trials, including dates of treatment and reasons for discontinuation.	

Medication	Dose / Strength	Directions	Quantity	Refills
☐ Ilumya™	☐ 100 mg prefilled syringe	☐ 100 mg SC day 0 and 28, then every 12 weeks.		
☐ Otezla®	☐ Starter Kit	☐ Taper per starter pack packaging		
	☐ 30 mg tablets	☐ 30 mg PO twice daily	#60	
		☐ 30 mg PO once daily	#30	
☐ Rinvoq®	☐ 15 mg tablets	☐ 15 mg PO once daily		
	☐ 30 mg tablets	☐ 30 mg PO once daily	#30	
☐ Siliq™	☐ 210 mg/ 1.5 mL single-dose prefilled syringe	☐ 210 mg SC day 0, 7 and 14, then every 2 weeks		
☐ Simponi®	☐ 50 mg/ 0.5 mL SmartJect® autoinjector	☐ 50 mg SC every 4 weeks		
	☐ 50 mg/ 0.5 mL prefilled syringe			
	☐ 100 mg/ mL SmartJect® autoinjector	☐ 200 mg SC day 0; 100 mg day 7; then 100 mg every 4 weeks		
	☐ 100 mg/ mL prefilled syringe			
☐ Skyrizi™	☐ 150 mg/ 1 mL pen	☐ Loading dose - 150 mg SC Week 0, Week 4		
	☐ 150 mg/ 1 mL syringe	☐ Maintenance dose - 150 mg SC every 12 weeks		
☐ Sotyktu®	☐ 6mg tablets	☐ 6mg PO once daily	#30	
☐ Stelara®	☐ 45 mg/ 0.5 mL prefilled syringe	☐ 45 mg SC days 0, 28 and then every 12 weeks		
	☐ 90 mg/ 1 mL prefilled syringe	☐ 90 mg SC days 0, 28 and then every 12 weeks		
☐ Taltz™	☐ 80 mg/ mL prefilled syringe	☐ 160 mg SC (two 80 mg injections) week 0, then 80 mg at weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks		
	☐ 80 mg / mL prefilled autoinjector			
☐ Tremfya™	☐ 100 mg / mL prefilled syringe	☐ 100 mg SC day 0 and 28, then every 8 weeks		
		☐ 100 mg SC every 8 weeks.		
☐ OTHER				

Prescriber Information				
Prescriber name:	**Phone:**	**Office contact name:**		
Prescriber address:	**City:**	**State:**	**Zip:**	
NPI:	**DEA:**	**Email / Fax:**		
Signature:	**Date:**	☐ **DO NOT SUBSTITUTE**		