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





	Pa	tient Information:	olease provide a	copy of the	e patient's insi	urance card o	rinformation			
Patient Name:			DOB:		Gender: □ F □ M		HT:			
Address: City: Insurance: Subscriber's name:			City:		State: Zip Code:			Phone:		
			y.			p = ====				
				ID#:				Group #:		
				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 / Psoriasis / Chronic Idiopathic Urticaria / Chronic Idiopathic Urticaria / Psoriasis / Psoriasi										
□ Hidradenitis Suppurativa / □ □ Other: □ □ Other: □										
	Diagnosed with: □ CHF □ Latex Allergy □ MS □ Hep B/C □ Malign			nancy Affected areas: □ palms □ soles				□ head □ neck □ genitalia		
PSO/PSA	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	dication Dose / Strength			Directions				Quantity	Refills	
□ Ilumya™	□ 100 mg prefilled syringe			☐ 100 mg SC day 0 and 28, then every 12 weeks.			weeks.	<u> </u>	1.00	
□ Otezla®	□ Starter Ki	• • •		☐ 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				#20		
	□ 30 mg tablets			□ 30 mg PO once daily #30						
☐ Siliq™					☐ 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								
		mL SmartJect® autoinjector		☐ 200 mg SC day 0; 100 mg day 7; then 100 mg every 4 weeks						
	□ 100 mg/ r	mL prefilled syringe								
□ Skyrizi™	☐ 150 mg/ 1			☐ Loading dose - 150 mg SC Week 0, Week 4 ☐ Maintenance dose - 150 mg SC every 12 weeks						
☐ 150 mg/1 mL syringe										
□ Sotyktu® □ Stelara®	3 3 4 4 4 4			☐ 6mg PO once daily				#30		
☐ Stelara® ☐ 45 mg/ 0.5 mL prefilled syringe ☐ 90 mg/ 1 mL prefilled syringe				☐ 45 mg SC days 0, 28 and then every 12 weeks						
☐ Taltz™			☐ 90 mg SC days 0, 28 and then every 12 weeks ☐ 160 mg SC (two 80 mg injections) week 0, then 80 mg at weeks							
- Tuine	•	mL prefilled syringe		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	e:		
Prescriber address:			1	City:			1	State:	Zip:	
NPI:		DEA:			Email / Fax:			ı		
Signature:				Date:			☐ DO NOT SUBSTITUTE			
oignature.						Date.			JOBOTHULE	

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