## DERMATOLOGY PRESCRIPTION FORM (Part 1)

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 |
|---|---|---|---|---|
| ☐ Adbry™ | ☐ 150 mg/ mL single-use prefilled syringe | ☐ Loaiding dose - 600mg SC<br>☐ Maintenance dose - 300mg SC every 2 weeks | | |
| ☐ Cibinqo® | ☐ 50 mg tablet<br>☐ 100 mg tablet<br>☐ 200 mg tablet | ☐ 50 mg PO once daily<br>☐ 100 mg PO once daily<br>☐ 200 mg PO once daily | #30 | |
| ☐ Cimzia® | ☐ Starter Kit<br>☐ 200 mg/ mL prefilled syringe<br>☐ 400 mg lyophilized vial | ☐ 400 mg SC weeks 0, 2 and 4<br>☐ 400 mg SC every 2 weeks | | |
| ☐ Cosentyx® | ☐ 150 mg/ mL single-use prefilled syringe<br>☐ 150 mg/ mL Sensoready pen | ☐ Loading dose - 300 mg SC weeks 0, 1, 2, 3, and 4<br>☐ Maintenance dose - 300 mg SC every 4 weeks | | |
| ☐ Dupixent® | ☐ 200 mg/ 1.14 mL solution in a single-dose pre-filled syringe with needle shield<br>☐ 300 mg/ 2 mL solution in a single-dose pre-filled syringe with needle shield | ☐ Loading dose - Inject 2 syringes SC on day 1 in two different injection sites<br>☐ Maintenance dose - Inject 1 syringe SC every other week | | |
| ☐ Enbrel® | ☐ 25 mg/ mL (latex free)<br>☐ 50 mg/ mL SureClick® autoinjector<br>☐ 50 mg/ mL prefilled syringe<br>☐ 50 mg/ mL solution in Enbrel MiniTM single-dose prefilled cartridge for use with the AutoTouch™ reusable autoinjector only | ☐ 50 mg SC twice weekly for 3 months<br>☐ 50 mg SC once weekly<br>☐ Other: | | |
| ☐ Humira® - Citrate Free **(Hidradenitis Suppurativa)** | ☐ Starter Kit - 80 mg / 0.8 mL pen<br>☐ 80 mg / 0.8 ml pen<br>☐ 40 mg / 0.4 ml pen | ☐ Inject 160 mg SC day 1; 80 mg day 15; two weeks later (day 29), begin a maintenance dose of 40 mg every week<br>☐ Inject 40 mg SC weekly starting day 29<br>☐ Inject 80 mg SC every other week starting day 29 | | |
| ☐ Humira® - Citrate Free **(PSO/PSA)** | ☐ Starter Kit - 80 mg / 0.8 mL and 40 mg / 0.4mL<br>☐ 40 mg/ 0.4 mL pens or prefilled syringes | ☐ Initial dose of 80 mg SC, followed by 40 mg every other week starting one week after initial dose<br>☐ 40 mg SC every other week | | |

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