

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Please fax a copy of front and back of the insurance card(s).

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) L40.8 (Other psoriasis)
 L40.9 (Psoriasis, unspecified) L40.5 (Psoriatic arthritis) L73.2 (Hidradenitis Suppurativa) _____

Diagnosis Date: _____ TB test: Yes No Neg. Test Date: _____ HBV: Yes No If yes, currently treated: Yes No
 BSA affected (%): _____ Affected areas: Palms Soles Head Neck Genitalia _____

Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Has the patient received their starter dose(s)/kit? Yes; Start Date _____ No

Prescription **Quantity** **Refill**

§ Cimzia®, Cosentyx®, Dupixent®, and Enbrel® are listed alphabetically on respective enrollment forms.§

<input type="checkbox"/> Humira® Citrate free (adalimumab)	Plaque Psoriasis <input type="checkbox"/> Initial: Inject 80mg SQ on day 1, then 40mg on day 8 then 40mg on day 22 <input type="checkbox"/> Maintenance: Inject 40mg SQ every 2 weeks	1 x 80 mg/0.8 mL and 2 x 40 mg/0.4 mL 2 x 40 mg/0.4 mL	Pens	0
	Hidradenitis Suppurativa <input type="checkbox"/> Initial: Inject 160mg SQ on day 1, then 80mg on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SQ every 2 weeks	2 x 80 mg/0.8 mL and 1 x 40 mg/0.4 mL 2 x 40mg/0.4 mL	Pens	0
<input type="checkbox"/> Ilumya (tildrakizumab-asmn)	<input type="checkbox"/> Inject 100mg SQ at week 0,4 and every 12 weeks thereafter	1 x 100mg/ml	PFS	_____
<input type="checkbox"/> Orencia® (abatacept) <i>Psoriatic Arthritis</i>	<input type="checkbox"/> Infuse _____ mg IV at week 0 and 2	_____ x 250 mg/mL	Vials	0
	<input type="checkbox"/> Infuse _____ mg IV at week 4 and every 4 weeks thereafter	_____ x 250 mg/mL	Vials	_____
	< 60 kg = 500 mg, 60 to 100 kg = 750 mg, > 100 kg = 1000 mg <input type="checkbox"/> Inject 125 mg SQ once weekly	4 x 125 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> ClickJect™ Autoinjector	_____
<input type="checkbox"/> Otezla® (apremilast)	<input type="checkbox"/> Take as directed per package instructions	55 tablets	28-day starter pack	0
	<input type="checkbox"/> Take 30 mg by mouth twice daily	60 x 30 mg	Tablets	_____

§ Siliq™, Simponi®, Simponi Aria®, Stelara®, Taltz® and Tremfya™ are listed alphabetically on respective enrollment forms.§

Injection Training Provided by: Physician's Office CoxHealth at Home Specialty Pharmacy Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home, and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.