BROADWAY SPECIALTY PHARMACY

Fax: 833.803.3110
Phone 800.640.8207
broadwayrx.health

DERMATOLOGY

1. PATIENT INFORMATION

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK and CLINICAL NOTES/LABS

NAME:		ADDRESS:	CITY:	STATE:	ZIP:
DOB:	SEX: ☐ F ☐ M	PHONE:	CELL PHONE:	SSN:	
HEIGHT:	WEIGHT:	HIPAA CONTACT/CAREGIVER:	ALLERGIES:	☐ LATEX ☐ NKDA	

2. CLINICAL INFORMATION

DATE OF DIAGNOSIS: ________ HISTORY: ☐ NEW ☐ RESTART ☐ CONTINUING | TB TEST: NEGATIVE DATE ________ HBV NEGATIVE OR TREATED: ☐ YES ☐ NO

DIAGNOSIS / ICD-10: ☐ ATOPIC DERMATITIS (L20.9) ☐ PSORIATIC ARTHRITIS (L40.5) ☐ PSORIASIS VULGARIS (L40.0) ☐ PSORIASIS UNSPECIFIED (L40.9) ☐ HIDRADENITIS SUPPURATIVA (L73.2) ☐ OTHER______

BSA % ______ HURLEY STAGE: ______ ☐ HANDS ☐ NAILS ☐ PALMS ☐ ARMS ☐ FEET ☐ SOLES ☐ LEGS ☐ SCALP ☐ FACE ☐ GROIN/GENITALS ☐ TORSO ☐ OTHER:________

FAILED TREATMENTS: ** ENTER LENGTH OF TREATMENT AND DATES BELOW/BESIDE FAILED THERAPY ** CURRENT THERAPY:

BIOLOGICS	☐ CIMZIA ☐ COSENTYX ☐ ENBREL ☐ HUMIRA ☐ ORENCIA ☐ REMICADE ☐ RITUXAN ☐ SIMPONI ☐ STELARA ☐ TALTZ
TOPICALS	☐ BETAMETHASONE ☐ CALCIPOTRIENE ☐ CLOBETASOL ☐ FLUOCINONIDE ☐ SALICYLIC ACID ☐ TAZAROTENE ☐ OTHERS ______________
ORAL MEDICATIONS	☐ METHOTREXATE ________ ☐ CYCLOSPORINE________ ☐ OTHER________________________ ☐ UVA ☐ UVB
NOTES:	

3. Rx

IF SHIPPING TO PRESCRIBER: NEXT APPT DATE: _______ ☐ FIRST FILL ☐ ALL FILLS | PATIENT RECEIVED STARTER DOSE: ☐ YES: DATE _______ ☐ NO

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ COSENTYX®	o 150mg/ml PFS o 150mg/ml Sensoready Pen Dose: o 150mg o 300mg	o **Loading Dose**: Inject Sub-Q weeks 0, 1, 2, and 3 o Inject Sub-Q on day 29 o **Maintenance Dose**: Inject Sub-Q every 4 weeks	4-Week Supply	1 ________
☐ DUPIXENT®	o 300mg/2 mL PFS w/ shield	o **Loading Dose**: Inject 600mg Sub-Q on Day 1 o **Maintenance Dose**: Inject 300mg Sub-Q every other week	2 4-Week Supply	None ________
☐ ENBREL®	o 25mg/0.5ml PFS o 25mg Vial o 50mg/ml Mini Cartridge o 50mg/ml PFS o 50mg/ml Sureclick	o <u>Adult Loading Dose: 50mg Sub-Q twice a week (3-4 days apart) for 3 months</u> o **Adult Maintenance Dose**: Inject 50mg Sub-Q once a week o **Pediatric Dose** > 138lb(63kg) Inject 50mg Sub-Q once a week o **Pediatric Dose** < 138lb(63kg) Inject 0.8mg/kg (______mg) Sub-Q once a week	8 4-Week Supply	2 ________
☐ HUMIRA®	o Psoriasis Starter Kit o 40mg Pen o 40mg PFS	o **Loading Dose**: Inject 80mg Sub-Q on Day 1, 40mg on Day 8, and every other week o Inject 40mg Sub-Q **EVERY OTHER** week	1 Starter Pack 4-Week Supply	None ________
	o HS Starter Kit o 40mg Pen o 40mg PFS	o **Loading Dose**: 160mg Sub-Q on day 1 OR 80mg Sub-Q days 1 & 2, then inject 80mg Sub-Q on day 15 o **Maintenance Dose**: Inject 40mq SQ weekly	1 Starter Pack 4-Week Supply	None ________
☐ ORENCIA®	o 125mg/ml ClickJect o 125mgml PFS	o Inject 125mg Sub-Q once a week	4-Week Supply	________
☐ OTEZLA®	o Starter Pack o 30mg Tablets	o **Loading Dose**: Take 1 tablet on day 1, then twice daily as directed. o **Maintenance Dose**: Take 1 tablet by mouth twice daily.	1 Starter Pack 60	None ________
☐ SIMPONI®	o 50mg/0.5ml SmartJect o 50mg/0.5ml PFS	o Inject 50mg Sub-Q once a month	4-Week Supply	________
☐ STELARA® WT:________	o 45mg PFS (<100kg/220lbs) o 45mg/ml Vial o 90mg PFS (>100kg/220lbs)	o **Loading Dose: <60kg(132lbs)** Inject 0.75mg/kg (____mg) Sub-Q on day 1 and day 29. o **Loading Dose**: Inject 1 PFS Sub-Q on day 1 and day 29. o **Maintenance**: Inject the contents of 1 PFS Sub-Q every 12 weeks	1	1 1 ________
☐ TALTZ®	o 80mg/mL Autoinjector o 80mg/mL PFS	o **Loading Dose**: Inject 160mg Sub-Q once, followed by 80mg at week 2, then o Inject 80mg Sub-Q weeks 4,6,8, and 10, then o Inject 80mg Sub-Q at week 12. o **Loading Dose: (Psoriatic Arthritis)**: Inject 160 mg Sub-Q on day 1 o **Maintenance Dose**: Inject 80mg Sub-Q every 4 weeks	3 2 1 2 1	None 1 None None ________
☐ TREMFYA®	o 100mg/ml PFS	o **Loading Dose**: Inject 100mg Sub-Q on week 1 and on day 29 o **Maintenance Dose**: Inject 100mg Sub-Q every 8 weeks	1 1	1 ________
☐ XELJANZ® ☐ XELJANZ XR®	o 5mg Tablet o 11mg Tablet	o Take one tablet by mouth twice daily o Take one tablet by mouth once daily	60 30	________ ________
☐				

4. PRESCRIBER INFORMATION

UPON PA DENIAL: ☐ SEND FORMULARY ALTERNATIVES ☐ DRAFT APPEAL

PRESCRIBER SIGNATURE: I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing Broadway Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-Pay Assistance/Foundations.

Signature: ______________________ Date:__________ Signature:______________________ Date: __________
Substitution Permitted — Dispense As Written

PRESCRIBER NAME:	ADDRESS:		CITY:	STATE:	ZIP:
OFFICE CONTACT:	PHONE:	FAX:	NPI:	DEA:	

*The information contained in this for is intended only for the use of individual or entity named. It contains confidential information, legally privileged, that may be protected health information under federal and state laws. If you are not the intended recipient, you are hereby notified that any dissemination, copying, or distribution of this communication is strictly prohibited. If you have received this form in error, please notify the sender and immediately destroy this communication.