Golden HealthCare Specialty

DERMATOLOGY [A-I]

Phone: 877-469-4334 Fax: 888-201-9023 NPI #: 1427479344
242 Palisade Avenue | Garfield, NJ 07026 goldhcrx.com

Today's Date _____ Needs by _____ Ship to Patient at ☐ Home ☐ Office ☐ Other _____

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Alt Phone _____
Email _____
SS# _____ DOB _____
☐ Male ☐ Female Height ____ ft ____ in Weight _____ ☐ kg ☐ lb
☐ **SEND COPY OF PATIENT'S INSURANCE CARDS: FRONT AND BACK**

PRESCRIBER INFORMATION

Prescriber Name _____
DEA# _____ NPI# _____ License# _____
Address/Suite _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Email _____
Contact Person _____
Best Contact via: ☐ Phone ☐ Fax ☐ Email ☐ Other _____

DIAGNOSIS/CLINICAL INFORMATION (PLEASE SEND A COPY OF ALL PERTINENT LABS AND CHART NOTES)

ICD-10 Diagnosis: ☐ **L20.9** Atopic Dermatitis ☐ **L40.0** Moderate to Severe Plaque Psoriasis ☐ **L40.50** Psoriatic Arthritis
☐ **L73.2** Hidradenitis Suppurativa, Hurley Stage: _____ ☐ **Other ICD-10** _____ Diagnosis _____
Allergies: _____ **Does patient have a latex allergy?** ☐ No ☐ Yes
Affected Areas: Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____
Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine ☐ Other: _____
Prior Failed Medications: Biologics: ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Simponi ☐ Stelara ☐ Taltz
☐ Methotrexate ☐ Soriatane ☐ Cyclosporine ☐ PUVA/UVB ☐ Topicals (list): _____ ☐ Other: _____
TB Test: ☐ No ☐ Yes Date: _____ Results: _____ (Please send lab results)

PRESCRIPTION INFORMATION

MEDICATION & DOSAGES	DIRECTIONS	QTY	REFILLS
☐ **Cimzia®** *(certolizumab pegol)* ☐ 200mg PFS ☐ 200mg Vials ☐ Starter Kit = 6 Vials or PFS ☐ *Enroll in CIMplicity*	**Plaque Psoriasis** ☐ **Load & Maintenance**: Inject 400mg (two-200mg injections) subcutaneously every other week ☐ **Load (For patients ≤ 90kg)**: Inject 400mg (two-200mg injections) at weeks 0, 2, and 4 ☐ **Maintenance (For patients ≤ 90kg)**: Inject 200mg subcutaneously every other week **Psoriatic Arthritis** ☐ **Load**: Inject 400mg (two-200mg injections) subcutaneously at weeks 0,2, and 4 ☐ **Maintenance**: Inject 400mg subcutaneously every 4 weeks ☐ **Maintenance**: Inject 200mg subcutaneously every 2 weeks	4 Week Supply 4 Week Supply 4 Week Supply 1 Starter Kit 4 Week Supply 4 Week Supply	_____ 0 _____ 0 _____ _____
☐ **Cosentyx®** *(secukinumab)* ☐ 300mg (2-150mg) Pen ☐ 150mg Pen ☐ 300mg (2-150mg) PFS ☐ 150mg PFS ☐ *Enroll in Consentyx Connect*	**Load**: Inject ☐ 300mg or ☐ 150mg subcutaneously at weeks 0,1,2,3,4 **Maintenance**: Inject ☐ 300mg or ☐ 150mg subcutaneously every 4 weeks	5 Week Supply 4 Week Supply	0 _____
☐ **Dupixent®** *(dupilumab) with shield* ☐ 300mg PFS (Adult & Adolescent ≥ 60kg) ☐ 200mg PFS (Adolescent < 60kg) ☐ *Enroll in MyWay™*	☐ **Load**: Inject 600mg (two-300mg injections in different sites) on day 1, then 300mg on day 15 ☐ **Maintenance**: Inject 300mg subcutaneously every other week	2 Syringes 2 Syringes	0 _____
	☐ **Load**: Inject 400mg (two-200mg injections in different sites) on day 1, then 200mg on day 15 ☐ **Maintenance**: Inject 200mg subcutaneously every other week	2 Syringes 2 Syringes	0 _____
☐ **Enbrel®** *(etanercept)* ☐ 50mg SureClick® ☐ 50mg PFS ☐ 50mg Mini® ☐ 25mg PFS ☐ 25mg Vial ☐ *Enroll in Enbrel Support*	**Adult Psoriasis** ☐ **Inject** 50mg subcutaneously once a week **Adult Psoriatic Arthritis** ☐ **Inject** 50mg subcutaneously twice a week for 3 months then 50mg subcutaneously once a week **Pediatric Psoriasis** ☐ **Inject** 0.8mg/kg subcutaneously once a week, with a maximum of 50mg per week Dose per week_____ Patient weight _____	4 Week Supply 4 Week Supply 4 Week Supply	_____ _____ _____
☐ **Erivedge®** *(vismodegib)* ☐ 150mg capsule	☐ **Take** one capsule by mouth daily ☐ *Enroll in Genentech Access Solutions*	28 capsules	_____
☐ **Humira® Citrate Free** *(adalimumab)* ☐ **Humira®** *(adalimumab)* ☐ Psoriasis Starter Pkg (Pens only) ☐ 40mg Pen ☐ 40mg PFS ☐ HS Starter Pkg *(Pens only)* ☐ *Enroll in Ambassador Program*	**Psoriasis** ☐ **Load**: Inject 80mg subcutaneously on day 1, then 40mg on day 8, and every other week thereafter ☐ **Maintenance**: Inject 40mg subcutaneously every other week **Hidradenitis suppurativa** **HS Adolescent: ≥ 60kg *HS Adolescents: 30-59kg* ☐ **Load**: Inject 160mg subcutaneously as ☐ two-80mg injections on day 1 **OR** ☐ one-80 mg injection on day 1 and then day 2, then inject 80mg on day 15, then inject 40mg every week thereafter starting on day 29 ☐ **Maintenance**: Inject 40mg subcutaneously every week	Loading Dose 4 Week Supply Loading Dose 4 Week Supply	0 _____ 0 _____
☐ **Ilumya®** *(tildrakizumab-asmn)* ☐ 100mg/ml PFS ☐ *Enroll in Ilumya Support™*	☐ **Load**: Inject 100 mg subcutaneously at weeks 0 and 4 ☐ **Maintenance**: Inject 100 mg subcutaneously every 12 weeks thereafter	Loading Dose 1 Syringe	2 _____

Prescriber's Signature (*no stamps*) _____ ☐ **Dispense as Written** **Date** _____

By signing above, I authorize GOLDEN HEALTHCARE SPECIALTY PHARMACY and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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Prescriber Name _____
DEA# _____ NPI# _____ License# _____
Address/Suite _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Email _____
Contact Person _____
Best Contact via: ☐ Phone ☐ Fax ☐ Email ☐ Other _____

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Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine ☐ Other: _____
Prior Failed Medications: Biologics: ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Simponi ☐ Stelara ☐ Taltz
☐ Methotrexate ☐ Soriatane ☐ Cyclosporine ☐ PUVA/UVB ☐ Topicals (list): _____ ☐ Other: _____
TB Test: ☐ No ☐ Yes Date: _____ Results: _____ (Please send lab results)

PRESCRIPTION INFORMATION

MEDICATION & DOSAGES	DIRECTIONS	QTY	REFILLS
☐ **Odomzo®** *(sonidegib)* ☐ 200mg Capsule ☐ *Enroll in Odomzo Patient Access Program*	☐ **Take** one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal	30 Capsules	_____
☐ **Otezla®** *(apremilast)* ☐ Starter Pack ☐ 30mg Tablet ☐ *Enroll in Otezla SupportPlus™*	☐ **Take** 1 tablet on day 1 then twice daily as directed or date provided _____ ☐ **Take** 1 tablet by mouth twice daily For Bridge Requests please utilize the *Otezla Support Plus Start Form* and fax to: **Golden HealthCare Pharmacy** at **888-201-9023**	1 Starter Pack 60 Tablets	0 _____
☐ **Siliq®** *(vismodegib)* ☐ 210mg PFS ☐ *Enroll in Siliq Solutions™*	☐ **Load**: Inject 210mg subcutaneously on weeks 0,1, and 2, then every 2 weeks thereafter ☐ **Maintenance**: Inject 210mg subcutaneously every 2 weeks	4 Syringes 2 Syringes	0 _____
☐ **Simponi®** *(brodalumab)* ☐ 50mg SmartJect® ☐ 50mg PFS ☐ *Enroll in SimponiOne®*	☐ **Inject** 50mg subcutaneously once a month as directed	1 Dose	_____
☐ **Skyrizi™** *(risankizumab-rzaa)* ☐ 75mg PFS ☐ *Enroll in Skyrizi Complete*	☐ **Load**: Inject 150mg (two-75mg syringes) subcutaneously on week 0 ☐ **Maintenance**: Inject 150mg (two-75mg syringes) SQ on week 4, then every 12 weeks thereafter	2 Syringes 2 Syringes	0 _____
☐ **Stelara®** *(ustekinumab)* ☐ 45mg PFS (Weight ≤100kg) ☐ 90mg PFS (Weight >100kg) ☐ 45mg Vial (For adolescents <60kg) ☐ *Enroll in Janssen CarePath*	☐ **Load**: Inject 1 syringe subcutaneously on week 0 ☐ **Maintenance**: Inject 1 syringe SQ on week 4, and then every 12 weeks thereafter ☐ **Load**: Inject _____ mg (0.75mg/kg) subcutaneously on week 0 ☐ **Maintenance**: Inject _____ mg (0.75mg/kg) subcutaneously on week 4, then every 12 weeks thereafter	1 Syringe 1 Syringe 1 Vial 1 Vial	0 _____ 0 _____
☐ **Taltz™** *(ixekizumab)* ☐ 80mg Autoinjector ☐ 80mg PFS ☐ *Enroll in Taltz Together™*	**Plaque Psoriasis** ☐ **Load**: Inject 160mg (two-80mg injections) subcutaneously on week 0, then 80mg every 2 weeks and weeks 2, 4, 6, 8, 10, and 12 ☐ **Maintenance**: Inject 80mg subcutaneously every 4 weeks **Psoriatic Arthritis** ☐ **Load** (Psoriatic arthritis): Inject 160mg (two-80mg injections) subcutaneously on week 0 ☐ **Maintenance**: Inject 80mg subcutaneously every 4 weeks	8 Doses 1 Dose 2 Doses 1 Dose	0 _____ 0 _____
☐ **Tremfya™** *(guselkumab)* ☐ 100mg One-Press Injector ☐ 100mg PFS ☐ *Enroll in Janssen CarePath*	☐ **Load**: Inject 100mg subcutaneously on week 0 ☐ **Maintenance**: Inject 100mg subcutaneously on week 4, then every 8 weeks thereafter	1 Dose 1 Dose	0 _____
☐ **Xeljanz®** *(tofacitinib)* ☐ 5mg Tablet ☐ 11mg XR Tablet ☐ *Enroll in XELSOURCE™*	**5mg Tablet** ☐ **Take** 2 tablets by mouth once daily ☐ **Take** 1 tablet by mouth daily (for moderate to severe renal/hepatic impairment) **11mg XR Tablet** ☐ **Take** 1 tablet by mouth daily	60 Tablets 30 Tablets 30 Tablets	_____ _____ _____
☐ **Other** _____			

Prescriber's Signature (*no stamps*) _____ ☐ **Dispense as Written** **Date** _____

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