SMP PHARMACY SOLUTIONS

Fax#: 855-447-6637
Ph#: 855-650-5009

Dermatology Prescription Faxable

Today's Date: _____ **Needed by:** _____ **Name:** _____ **Phone:** _____

Patient Demographic: (Provide the following or attached demographic sheet)
Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
SS#: _____ Date Birth: _____
Gender: _____ Height: _____ Weight _____ BSA _____ m2

Prescriber: (Provide as much information as possible)
Prescriber's Name: **Dr. Sims-Robertson** Group/Hospital: **Divine Dermatology**
Specialty: **Dermatology** NPI #: **1689688830** DEA: _____
Address: **2191 9th ave N #100**
City, State, Zip: **St. Petersburg, FL 33713**
Phone: **727-528-0321** Fax: **727-498-8832**
Alt. Contact Name: **Angela Wilson**
Phone: **727-528-0321** Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):
Primary Insurance Name: _____ ID#: _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
☐ No Insurance ☐ Patient will pay out of pocket ☐ Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):
☐Patient Address ☐First Fill Physician's Office, Refill to Patient Address ☐Patient will pick up at Pharmacy

Diagnosis (ICD-10 code): ☐ L40.0 Psoriasis Vulgaris ☐ L40.1 Generalized Pustular Psoriasis ☐ L40.4 Guttate Psoriasis
☐ L40.50 Arthropatic Psoriasis, Unspecified ☐ L40.54 Psoriatic Arthritis ☐ L40.59 Other Psoriatic Arthropathy ☐ L40.8 Other Psoriasis
☐ L40.9 Psoriasis, Unspecified ☐ L73.2 Hidradenitis Suppurativa ☐ Other _____ Psoriasis Type: ☐ Plaque
☐ other: ☐ Comorbidity: ☐ Date of Diagnosis: **OR** Years with Disease: Disease State Severity: ☐ Severe ☐ Moderate

Injection Training & Educational Needs: ☐ Specialty Pharmacy Injection Training Requested ☐ Manufacturer's Patient Assistance Program Enrollment Requested **OR** (Please Choose only one) ☐ Physician's Office already trained Patient ☐ Patient is already independently

Patient Allergies/ Allergic reactions:
1. _____ 2. _____

Prior (Failed) Medications (Reason for D/C):
1. _____ 2. _____

MEDICATION	DOSE/STRENGTH	DIRECTION	QTY.	REFS.
☐**Cosentyx®**	☐ 150mg/ml	☐ **Plaque Psoriasis**: *Induction Dose*: Inject 300 mg SC at weeks 0,1,2,3, and 4.		
		☐ **Plaque Psoriasis**: *Maintenance Dose*: Inject 300mg SC every 4 week.		
		☐ **Psoriatic Arthritis**: *Induction Dose*: 150mg at weeks 0,1,2,3, and 4 every 4 weeks.		
		☐ **Psoriatic Arthritis**: *Maintenance Dose*: 150mg every 4 weeks.		
☐**Enbrel®**	☐ 50 mg/ml Sureclick ☐ 50 mg/ml Prefilled Syr ☐ 25 mg/0.5ml Prefilled Syr ☐ 25 mg Vial	☐ **Psoriasis**: *Induction Dose*: Inject 50mg SC Twice a week (3-4 days apart) for 3month. ☐ **Psoriasis**: *Maintenance Dose*: Inject 50mg SC once a week.		
		☐ **Psoriatic Arthritis Dose**: Inject 50mg SC once a week.		
		☐ Other:		
☐**Humira®**	☐ Psoriasis Starter Package	☐ **Psoriasis**: *Induction Dose*: Inject 80mg SC on day 1, then one 40mg on day 8, then 40mg every other week.	1 Package	0
	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syr	☐ **Psoriasis**: *Maintenance Dose*: Inject 40mg SC every other week.		
		☐ **Psoriatic Arthritis Dose**: Inject 40mg SC every other week.		
		☐ Other:		
☐**Remicade®**	☐ 100 mg Vial	☐ *Induction Dose*: Infuse 5mg/kg (Dose= _____mg) in 250ml of 0.9% NaCl at week 0, week 2, week 4 and every 8 weeks thereafter.	_____ # of 100mg Vials	
		☐ *Maintenance Dose*: Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 weeks.	_____ # of 100mg Vials	
		☐ Other:		
☐**Simponi®**	☐ 50 mg/0.5ml Smartject Auto Injector ☐ 50 mg/0.5ml Prefilled Syr	☐ **Psoriasis Arthritis Dose**: Inject 50mg (0.5ml) SC once a month.		
		☐ Others:		
☐**Stelara®**	☐ 45 mg/0.5ml Prefilled Syr ☐ 90 mg/1ml Prefilled Syr	☐ For patients weighing <100kg (220lbs): Inject 45 mg SC initially and 4 weeks later followed by 45mg every 12 weeks. ☐ For patients weighing >100kg (220lbs): Inject 90 mg SC initially and 4 weeks later followed by 90mg every 12 weeks.		
☐**Otelza®**	☐ Titration Starter Pack Rx	Day 1: 10mg orally in the morning. Day 2: 10mg orally in the morning and 10mg orally in the evening. Day 3: 10mg orally in the morning and 20mg orally in the evening. Day 4: 20mg orally in the morning and 20mg orally in the evening. Day 5: 20mg orally in the morning and 30mg orally in the evening. Day 6: and thereafter 30mg orally twice a day.	1 Pack	0
	☐ 30 mg	Take one tablet twice a day		

☐ Sharps Package: (Sterile sponges, alcohol swabs, sharps container)

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescribe Signature: _____ Date: ____/____/____