

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Dermatology P-Z Prescription Form

Patient information

Patient: _____ Female Male DOB: _____ Insurance plan: _____ Plan ID #: _____
 Address: _____ City: _____ State: _____ ZIP code: _____
 Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Clinical information

Height: _____ Weight: _____ lb kg Date: _____ ICD-10 code: _____ Diagnosis: _____ Diagnosis date: _____
 BSA: _____ m² TB test: No Yes Negative test date: _____ HBV: No Yes If yes, currently treated? No Yes
 % BSA affected: _____ Affected areas: Hands Feet Head Neck Other: _____
 Concurrent medications: _____ Other medical conditions: _____ Allergies: No Yes: _____
 Previous therapy: _____ Discontinuation reason: _____ Dates: _____

Prescription information Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> Take one tablet (15mg) PO once daily <input type="checkbox"/> Take one tablet (30mg) PO once daily	<input type="checkbox"/> 1 month	___
<input type="checkbox"/> Siliq PFS (brodalumab)	<input type="checkbox"/> Inject 210 mg SQ on weeks 0, 1 and 2, followed by 210 mg SQ every 2 weeks thereafter.	<input type="checkbox"/> 1 month	0
	<input type="checkbox"/> Inject 210 mg SQ every 2 weeks.	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	___
<input type="checkbox"/> Simponi (golimumab) <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 50 mg SQ once a month.	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	___
	<input type="checkbox"/> Infuse _____ mg (2mg/kg x _____ kg) over 30 minutes at week 0. <input type="checkbox"/> Infuse _____ mg (2mg/kg x _____ kg) over 30 minutes at week 4 and every 8 weeks thereafter.	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	0 ___
<input type="checkbox"/> Skyrizi PFS (risankizumab)	<input type="checkbox"/> Inject 150 mg SQ at week 0.	<input type="checkbox"/> 28 days	0
	<input type="checkbox"/> Inject 150 mg SQ at week 4, and inject 150 mg SQ every 12 weeks thereafter.	<input type="checkbox"/> 84 days	___
<input type="checkbox"/> Stelara (ustekinumab) <input type="checkbox"/> PFS <input type="checkbox"/> Vials (pediatric dose)	<input type="checkbox"/> Inject 45 mg SQ on day 1. <input type="checkbox"/> Inject 90 mg SQ on day 1 (> 100 kg). <input type="checkbox"/> Inject _____ mg (0.75 mg/kg x _____ kg) SQ on day 1 (pediatric < 60kg).	<input type="checkbox"/> 1 month	0
	<input type="checkbox"/> Inject 45 mg SQ on day 29 and every 12 weeks thereafter. <input type="checkbox"/> Inject 90 mg SQ on day 29 and every 12 weeks thereafter (> 100 kg). <input type="checkbox"/> Inject _____ mg (0.75 mg/kg x _____ kg) SQ on day 29 and every 12 weeks thereafter (pediatric < 60 kg).	<input type="checkbox"/> 84 days <input type="checkbox"/> _____	___
	<input type="checkbox"/> Weeks 0–2: Inject 160mg SQ at week 0, then inject 80 mg SQ at week 2. <input type="checkbox"/> Weeks 4–10: Inject 80 mg SQ at week 4 and every 2 weeks thereafter, through week 10.	<input type="checkbox"/> 1 month	1
	<input type="checkbox"/> Week 12 onward: Inject 80 mg SQ at week 12 and every 4 weeks thereafter.	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	___
<input type="checkbox"/> Tremfya PFS (guselkumab) <input type="checkbox"/> One-Press Injector <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 100 mg SQ at week 0.	<input type="checkbox"/> 28 days	0
	<input type="checkbox"/> Inject 100 mg SQ at week 4 and every 8 weeks thereafter.	<input type="checkbox"/> 56 days <input type="checkbox"/> _____	___
<input type="checkbox"/> Xeljanz 5 mg tab	<input type="checkbox"/> Take 5 mg by mouth twice daily.	<input type="checkbox"/> 1 month	___
<input type="checkbox"/> Xeljanz XR 11 mg tab	<input type="checkbox"/> Take 11 mg by mouth once daily.	<input type="checkbox"/> _____	___

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____
 Ship to: Patient Office Other: _____
 Office address: _____ City: _____ State: _____ ZIP code: _____
 Office phone number: _____ Office fax number: _____
 Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language.
 Noncompliance with state-specific requirements could result in outreach to the prescriber.