LeMed
SPECIALTY PHARMACY

DERMATOLOGY

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Bronx, NY 10451
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Patient Information - Please send demographic sheet and a copy of the patient's insurance cards			
Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:	Language:	
Allergies **(Required):** ☐ NKDA	Height: Weight:	SSN:	
Medication Delivery Options: ☐ Patient's Home ☐ Hospital/Clinic Office ☐ Bedside **Delivery Address:**			

Prescriber Information			
Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
Clinical Information - Please send all available chart notes including lab results	**ICD-10:**		
Therapies tried and failed with length of treatments:			

Medication Name	Strength	Dose/Frequency
☐ Cimzia (1 Starter Pack)	200 mg PFS	**Initial dose:** Inject 400 mg SC at weeks 0, 2 and 4
☐ Cimzia (1 kit)	200 mg PFS	**Maintenance dose:** ☐ Inject 400 mg SC once every 4 weeks ☐ Inject 200 mg SC once every 2 weeks
☐ Cosentyx (5 PFS/Pens)	☐ 150 mg/ml Sensoready Pen ☐ PFS	☐ **With loading dose:** Inject 150 mg SC at weeks 0, 1, 2, 3, 4 then every 4 weeks thereafter
☐ Cosentyx (1 PFS)	☐ 150 mg/ml Sensoready Pen ☐ PFS	☐ **Without loading dose:** Inject 150 mg SC every 4 weeks
☐ Dupixent (2 PFS)	300 mg/2 ml	**Initial dose:** Inject 600 mg SC on day one
☐ Dupixent (2 PFS)	300 mg/2 ml	**Maintenance dose:** Inject 300 mg SC every other week (starting on day 15)
☐ Enbrel (8 PFS)	☐ 50 mg ☐ SureClick	**Initial dose:** Inject 50 mg SC twice weekly for 3 months
☐ Enbrel (4 PFS)	☐ 50 mg ☐ SureClick	**Maintenance dose:** Inject 50 mg SC once weekly
☐ Enstilar Foam	0.005%/0.064%	Apply to affected areas QD for 4 weeks
☐ Humira (1 month)	☐ 40 mg /0.4 ml (CF) Pen ☐ PFS	**Initial dose:** Inject 80 mg SC on day 1
☐ Humira (1 month)	☐ 40 mg /0.4 ml (CF) Pen ☐ PFS	**Maintenance dose:** Inject 40 mg SC every other week starting 1 week after initial dose
☐ Humira (1 month)	☐ 40 mg /0.4 ml (CF) Pen ☐ PFS	**Hidradenitis Supparativa only:** **Initial dose:** Inject 160 mg SC on day one, 80 mg 14 days later, 40 mg on day 29 **Maintenance dose:** Inject 40 mg SC every week starting one week after day 29
☐ Ilumya	100 mg/ml PFS	Inject 100 mg SC weeks 0,4, and then every 12 weeks thereafter
☐ Orencia	☐ 125 mg PFS ☐ autoinjector	Inject 125 mg SC once weekly
☐ Otezla (1 Starter Pack)	30 mg STARTER PACK	**Titration:** Take 1 tablet on day 1, then take twice daily as directed
☐ Otezla (60 tablets)	30 mg tablets	Take 1 tablet by mouth twice daily
☐ Picato Gel	☐ 0.015% ☐ 0.05%	☐ Apply to the affected areas of face and scalp once daily for 3 consecutive days ☐ Apply to the affected areas of trunk and extremities once daily for 2 consecutive days
☐ Siliq (3 PFS)	210 mg/1.5 ml PFS	**Initial dose:** Inject 210 mg SC at weeks 0, 1, 2 and then every 2 weeks thereafter
☐ Siliq (2 PFS)	210 mg/1.5 ml PFS	**Maintenance dose:** Inject 210 mg SC every 2 weeks
☐ Simponi (1 month)	☐ 50 mg/0.5 ml PFS ☐ 50 mg SmartJect	Inject 50 mg SC once a month
☐ Skyrizi	75 mg/0.83 ml PFS	Inject 75 mg SC weeks 0,4, and then every 12 weeks thereafter
☐ Stelara (1 PFS)	☐ 45 mg PFS (< 100 kg) ☐ 90 mg PFS (> 100 kg)	**Initial dose:** Inject 1 syringe SC initially then 4 weeks later, then every 12 weeks
☐ Stelara (1 PFS)	☐ 45 mg PFS (< 100 kg) ☐ 90 mg PFS (> 100 kg)	**Maintenance dose:** Inject 1 syringe SC every 12 weeks
☐ Taltz	☐ 80 mg/ml PFS ☐ autoinjector	Inject 160 mg SC at weeks 2,4,6,8,10,12, then 80 mg every 4 weeks
☐ Tremfya (1 PFS)	100 mg/ml PFS	**Initial dose:** Inject 1 syringe SC at weeks 0, 4, then every 8 weeks
☐ Tremfya (1 PFS)	100 mg/ml PFS	**Maintenance dose:** Inject 1 syringe SC every 8 weeks
☐ Xeljanz (60 tablets)	5 mg	Take 1 tablet by mouth twice daily
☐ Xeljanz XR (30 tablets)	11 mg	Take 1 tablet by mouth once daily

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize LeMed Specialty Pharmacy and/or its affiliate pharmacies to facilitate benefits investigations, complete and submit prior authorization (PA) requests, appeals, step edits and other processes necessary to obtain coverage for prescribed medications, to sign any necessary forms on my behalf of my patients, and to attach its Enrollment Form to the PA request as my signature.

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Prescriber Signature: _____ **Date:** _____