

Deliver to:  Patient's Home  Prescriber's Office  Other: \_\_\_\_\_  Hold shipment until notified by prescriber  Anticipated Start Date: \_\_\_\_\_

### 1. Patient Information

Last Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Mobile Phone: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Home Address: \_\_\_\_\_  
 S.S. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Guardian/Caregiver: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs.  kg.

### 2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Prescription Card: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ BIN/PCN: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

### 3. Prescriber Information

Prescriber Name: \_\_\_\_\_  MD  DO  NP  PA License #: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Collaborating Physician: \_\_\_\_\_

### 4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: \_\_\_\_\_ Secondary ICD-10: \_\_\_\_\_ Meds Tried & Failed: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Concurrent Medications: \_\_\_\_\_  
 Vaccination History: \_\_\_\_\_

### 5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
COSENTYX®	<input type="checkbox"/> 150 mg/mL PFS <input type="checkbox"/> 150 mg/mL Sensoready® Pen	<input type="checkbox"/> Initial dose: Inject 300 mg SC at weeks 0, 1, 2, 3, & 4	5	0
		<input type="checkbox"/> Maintenance dose: Inject 300 mg SC Q4wks	1	
CIMZIA®	<input type="checkbox"/> 200 mg Starter Kit <input type="checkbox"/> 200 mg PFS Kit	<input type="checkbox"/> Initial dose: Inject 400 mg SC QW at weeks 0, 2, & 4		
	<input type="checkbox"/> 200 mg Vial Kit	<input type="checkbox"/> Maintenance dose: Inject 400 mg SC Q4wks <input type="checkbox"/> Maintenance dose: Inject 200 mg SC Q4wks		
DUPIXENT®	<input type="checkbox"/> 300 mg/2 mL 2-PFS	<input type="checkbox"/> Initial dose: Inject 600 mg SC (two different injection sites), then 300mg SC every other week	2	0
		<input type="checkbox"/> Maintenance dose: Inject 300 mg SC every other week	1	
ENBREL®	<input type="checkbox"/> 25 mg PFS <input type="checkbox"/> 50 mg PFS	<input type="checkbox"/> Inject 50 mg SC BIW for 3 months followed by 50 mg QW		
	<input type="checkbox"/> 25 mg Vial <input type="checkbox"/> 50 mg Sureclick Autoinjector	<input type="checkbox"/> Inject 50 mg SC QW		
HUMIRA®	<input type="checkbox"/> Psoriasis/Uveitis Starter Pack (4x40 mg/0.8 mL Pens)	• Day 1: Inject 80 mg SC x 1 dose • Day 8 and after: Inject 40 mg SC	1 Kit	
	<input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Pen	• Inject 40 mg SC every other week	1 Kit	
ILUMRYA™	<input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS			
	<input type="checkbox"/> 100 mg/mL PFS	<input type="checkbox"/> Initial dose: Inject 100 mg SC at week 0 & 4	2	0
OTEZLA®	<input type="checkbox"/> 28 Day Starter Pack	<input type="checkbox"/> Maintenance dose: Inject 100 mg SC Q12wks	1	
	<input type="checkbox"/> Maintenance dose: 30 mg	• Day 1: Take 10 mg PO QAM • Day 2: Take 10 mg PO BID • Day 3: Take 10 mg PO QAM & 20 mg QPM		
SIMPONI®	<input type="checkbox"/> 50 mg/0.5 mL PFS <input type="checkbox"/> 50 mg/0.5 mL Autoinjector	• Day 4: Take 20 mg PO BID • Day 5: Take 20 mg PO QAM & 30 mg QPM • Day 6: Take 30 mg PO BID	1 Pack	
SKYRIZI™	<input type="checkbox"/> 75 mg/0.83 mL PFS	• Inject 50 mg SC once a month	1	
STELARA®	<input type="checkbox"/> 45 mg/0.5 mL PFS <input type="checkbox"/> 90 mg/1mL PFS	• Inject 150 mg (two 75 mg injections) SC at weeks 0 and 4, then 150 mg Q12wks	1 Carton	
		<input type="checkbox"/> (<=100kg (220 lbs): Inject 45 mg SC at weeks 0 and 4, then 45 mg Q12wks		
TALTZ®	<input type="checkbox"/> 80 mg PFS <input type="checkbox"/> 80 mg Autoinjector	<input type="checkbox"/> (>100kg (220 lbs): Inject 90 mg SC at weeks 0 and 4, then 90 mg Q12wks		
		<input type="checkbox"/> Initial dose: Inject 160 mg SC at week 0, followed by 80 mg at weeks 2 & 4	4	0
		<input type="checkbox"/> Initial dose: Inject 80 mg SC at weeks 6, 8, 10 & 12	2	1
TREMFYA®	<input type="checkbox"/> 80 mg PFS <input type="checkbox"/> 80 mg Autoinjector	<input type="checkbox"/> Maintenance dose: Inject 80 mg SC Q4wks	1	
	<input type="checkbox"/> 100 mg PFS	<input type="checkbox"/> Initial dose: Inject 100 mg SC at week 0 & 4	2	0
		<input type="checkbox"/> Maintenance dose: Inject 100 mg SC Q8wks	1	

**Patient Support Programs:** Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

**Account Manager**

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible

PREScriBER SIGNATURE REQUIRED. NO STAMPS.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Prescriber Signature-Dispense as Written

PREScriBER SIGNATURE REQUIRED. NO STAMPS.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_