

PATIENT INFORMATION	PHYSICIAN INFORMATION
Patient Name: _____	Physician Name: _____
Address: _____	Contact: _____
City, State, Zip: _____	NPI #: _____
Phone #: _____ Secondary Phone #: _____	Address: _____
Patient SSN#: _____ Date of Birth: _____	_____
Weight (lbs): _____ Height (in.): _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	City, State, Zip Code
Allergies: _____	Phone #: _____
Primary Insurance: _____	Alt Phone #: _____
ID#: _____ Phone #: _____	Fax #: _____
Secondary Insurance: _____	Email: _____
ID#: _____ Phone #: _____	Ship Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's home
FAX COPY OF INSURANCE CARD (FRONT & BACK)	

CLINICAL INFORMATION		
<p style="text-align: center;">ICD-10 Diagnosis</p> <input type="checkbox"/> L40.0 Psoriasis vulgaris <input type="checkbox"/> L40.8 Other psoriasis <input type="checkbox"/> L40.9 Psoriasis, unspecified <input type="checkbox"/> L40.5 Psoriatic arthritis <input type="checkbox"/> L73.2 Hidradenitis suppurativa	Date of Diagnosis: _____ Date of negative TB test: _____ HBV: <input type="checkbox"/> Yes <input type="checkbox"/> No BSA affected (%): _____ Affected areas: <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Genitalia Comorbidities: _____ Medication Reconciliation: _____	
Prior Treatment/Therapy (If Any)	Reason for Discontinuation	Start and End Date of Therapy
_____	_____	_____
_____	_____	_____
_____	_____	_____
FAX COPY OF ALL RELATED CLINICAL/LAB INFO		

MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> HUMIRA® ADALIMUMAB	<input type="checkbox"/> Inject 80 mg SQ on day 1, 40 mg on day 8, and 40 mg every 2 weeks after <input type="checkbox"/> Inject 160 mg SQ on day 1, 80 mg on day 15 <input type="checkbox"/> _____	<input type="checkbox"/> 4x40 mg/0.8 mL <input type="checkbox"/> 6x40 mg/0.8 mL <input type="checkbox"/> PFS <input type="checkbox"/> Pens	0
	<input type="checkbox"/> Inject 40 mg subcutaneously every 2 weeks <input type="checkbox"/> Inject 40 mg subcutaneously on day 29 and every week after	<input type="checkbox"/> 2x40 mg/0.8 mL <input type="checkbox"/> 4x40 mg/0.8 mL <input type="checkbox"/> PFS <input type="checkbox"/> Pens	
<input type="checkbox"/> OTEZLA® APREMILAST	<input type="checkbox"/> Take as directed on package instructions <input type="checkbox"/> Take 30 mg twice daily by mouth <input type="checkbox"/> _____	<input type="checkbox"/> 28 day starter pack <input type="checkbox"/> 55 tablets <input type="checkbox"/> 60x30mg tablets <input type="checkbox"/> _____	0
	<input type="checkbox"/> SIMPONI® GOLIMUMAB	<input type="checkbox"/> Inject 50 mg SQ once a month	<input type="checkbox"/> 1x150 mg/mL <input type="checkbox"/> 2x150 mg/mL <input type="checkbox"/> PFS <input type="checkbox"/> Sensoready® Pen

Injection Training Provided By: Physician's Office Delta Drugs | Dispense As Written

Physician's Signature: _____	Date: _____
I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.	