Publix Specialty Pharmacy #3213
DERMATOLOGY (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

PATIENT INFORMATION [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/_____ ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

CLINICAL INFORMATION [Attach copy of labs and clinical notes]

Diagnosis code(s): _____ Diagnosis: ☐Psoriasis (PsO) ☐Psoriatic Arthritis (PsA) ☐Hidradenitis Suppurativa (HS) ☐Atopic dermatitis ☐Other: _____

Treatment status: ☐New to therapy Previously denied by insurance? ☐No ☐Yes, include copy of denial letter Weight: _____ ☐kg ☐lb

☐Continuation of therapy, start date: ___/___/_____ Is the patient on samples? ☐No ☐Yes Height: _____ ☐cm ☐in

TB test results (within 6 months): ☐N/A ☐Negative ☐Positive, Date of TB test: ___/____/_____ Allergies: ☐ NKDA ☐Other: _____

Prior therapy, treatment dates, and reason for discontinuation: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Cimzia (certolizumab pegol)	☐Starter Kit: 6 x 200 mg/mL prefilled syringe (PFS) ☐200 mg vial	Initial Dose: Inject 400 mg SC on days 1, 15 and 29	3 doses (6 PFS/vials)	0
	☐200 mg/mL PFS ☐200 mg vial	Maintenance Dose: ☐Inject 400 mg SC every 2 weeks ☐Inject 400 mg SC every 4 weeks ☐Inject 200 mg SC every 2 weeks	☐28 days ☐84 days	_____
☐ Cosentyx (secukinumab)	☐150 mg/mL Sensoready pen ☐150 mg/mL PFS	Initial Dose: ☐Inject 300 mg SC once a week for 5 weeks (days 1, 8, 15, 22, and 29) ☐Inject 150 mg SC once a week for 5 weeks (days 1, 8, 15, 22, and 29)	5 doses	0
		Maintenance Dose: ☐Inject 300 mg SC every 4 weeks ☐Inject 150 mg SC every 4 weeks	☐28 days ☐84 days	_____
☐ Dupixent (dupilumab)	☐300 mg/2mL pen ☐300 mg/2mL PFS	Initial Dose: ☐Inject 600 mg SC on day 1	1 dose (2 PFS)	0
		Maintenance Dose: ☐Inject 300 mg SC every 2 weeks starting on day 15	☐28 days ☐84 days	_____
☐ Enbrel (etanercept)	☐50 mg/mL Mini cartridge ☐50 mg/mL SureClick pen ☐50 mg/mL PFS ☐25 mg/0.5 mL PFS	Initial Dose: ☐Inject 50 mg SC twice a week (3-4 days apart) for 12 weeks	84 days	0
		Maintenance Dose: ☐Inject 50 mg SC ONCE a week ☐Inject 25 mg SC TWICE a week (3-4 days apart)	☐28 days ☐84 days	_____
☐ Humira (adalimumab)	☐PsO Starter Kit: 1 x 80 mg/0.8 mL pen (citrate-free) & 2 x 40 mg/0.4 mL pens (citrate-free) ☐PsO Starter Kit: 4 x 40 mg/0.8 mL pens	Initial Dose (for PsO): Inject 80 mg SC on day 1, then 40 mg every 2 weeks starting on day 8	35 days (1 kit)	0
	☐HS Starter Kit: 3 x 80 mg/0.8 mL pens (citrate-free) ☐HS Starter Kit: 6 x 40 mg/0.8 mL pens	Initial Dose (for HS): ☐Inject 160 mg SC on day 1, then 80 mg on day 15 ☐Inject 80 mg SC on days 1, 2, and 15	28 days (1 kit)	0
	☐40 mg/0.4 mL pen (citrate-free) ☐40 mg/0.8 mL pen ☐40 mg/0.4 mL PFS (citrate-free) ☐40 mg/0.8 mL PFS	Maintenance Dose: ☐Inject 40 mg SC every 2 weeks ☐Inject 40 mg SC once a week	☐28 days ☐84 days	_____
☐ Ilumya (tildrakizumab -asmn)	100 mg/mL PFS	Initial Dose: ☐Inject 100mg SC on day 1	1 dose	0
		Maintenance Dose: ☐Inject 100mg SC every 12 weeks starting on day 29	84 days	_____
☐ Orencia (abatacept)	☐125 mg/mL ClickJect pen ☐125 mg/mL PFS	☐Inject 125 mg SC once a week	☐28 days ☐84 days	_____
☐ Otezla (apremilast)	☐Starter Pack: 55 tablets	Initial dose: Take as directed per package instructions	28 days (1 pack)	0
	☐30mg tablet	Maintenance dose: Take 1 tab PO BID	☐30 days ☐90 days	_____

PRESCRIBER INFORMATION [Ship to prescriber: ☐ Never ☐Always ☐First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐No ☐Yes

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted)

_____ ☐Substitution allowed Date

_____ ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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Prior therapy, treatment dates, and reason for discontinuation: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Siliq (brodalumab)	210 mg/1.5 mL prefilled syringe (PFS)	Initial Dose: ☐Inject 210 mg SC on days 1 and 8	2 doses	0
		Maintenance Dose: ☐Inject 210 mg SC every 2 weeks starting on day 15	☐28 days ☐84 days	_____
☐ Simponi (golimumab)	☐50 mg/mL auto-injector ☐50 mg/mL PFS	Inject 50 mg SC once monthly	☐30 days ☐90 days	_____
☐ Skyrizi (risankizumab)	75 mg/0.83 mL PFS	Initial Dose: ☐Inject 150 mg SC on day 1	1 dose	0
		Maintenance Dose: ☐Inject 150 mg SC every 12 weeks starting on day 29	84 days	_____
☐ Stelara (ustekinumab)	☐90 mg/mL PFS ☐45 mg/0.5 mL PFS Patient weight: _____	Initial Dose: ☐Inject 1 dose SC on day 1	1 dose	0
		Maintenance Dose: ☐Inject 1 dose SC every 12 weeks starting on day 29	84 days	_____
☐ Taltz (ixekizumab)	☐80 mg/mL auto-injector ☐80 mg/mL PFS	Initial Dose (for PsO): ☐Inject 160 mg SC on day 1 Inject 80 mg SC every 2 weeks for 6 doses (weeks 2 through 12)	1 dose 6 doses	0
		Initial Dose (for PsA): ☐Inject 160 mg SC on day 1	1 dose	0
		Maintenance Dose: ☐Inject 80 mg SC every 4 weeks	☐28 days ☐84 days	_____
☐ Tremfya (guselkumab)	☐100 mg/mL auto-injector ☐100 mg/mL PFS	Initial Dose: ☐Inject 100mg SC on day 1	1 dose	0
		Maintenance Dose: ☐Inject 100mg SC every 8 weeks starting on day 29	56 days	_____
☐ Xeljanz (tofacitinib)	☐5 mg tablet	Take 1 tab PO BID with or without food	☐30 days ☐90 days	_____
	☐11 mg XR tablet	Take 1 tab PO once daily with or without food		
☐ Other: _____	_____	_____	_____	_____

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