GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: _____

DERMATOLOGY PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
Address: _____ Date of Birth: _____
City, State,Zip: _____ SSN: _____
Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home
☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: _____ Date of Diagnosis/ Years with disease: _____ Try and Fail medications: _____
Weight: _____lbs / kg Height: _____ Allergies: _____ %BSA affected _____ TB Test: _____

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Enbrel®	☐50mg/ml PFS ☐25mg/ml PFS ☐Other:	☐ Inject 50mg SC Twice a week for 3 months ☐ Inject 50mg SC once a week ☐ Other:		
☐ Humira®	☐ 20mg/0.4ml PFS (2 doses) ☐ 40mg/0.4ml PFS (2 doses) ☐ Other:	☐ Inject two 40mg SC day 1; then 40mg SC day 8; then 40mg SC every other week ☐ Inject 40mg SC every other week ☐ Other:		
☐ Simponi®	☐ 50mg/0.5ml Auto-injector ☐ 50mg/0.5ml PFS	☐ Inject 50mg SC once a month		
☐ Stelara®	☐ 45mg/0.5ml PFS ☐ 90mg/1ml PFS	☐ Patient<100kg: Inject 45mg SC at day 1; then 45mg SC day 30 and then every 12 weeks ☐ Patient>100kg: Inject 90mg SC at day 1; then 90mg SC day 30 and then every 12 weeks ☐ Other:		
☐ Oxsoralen-Ultra®	☐ 10mg			

☐ Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ ☐**Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____