PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

PEDIATRIC DERMATOLOGY ORDER FORM

Ship to: ☐ Patient ☐ Physician ☐ Other **Need:** ☐ Nurse ☐ Training
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: ______________________ DOB: ______________ SSN: ______________

Address: ______________________

City: ______________________ State: ____________ Zip: ______________

Phone: ______________________ Alt Phone: ______________________

Alternate Contact Info: ______________________

Allergies: ______________________

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Gender: ☐ Male ☐ Female

Height: ______________

Weight: ______________

BSA: ______________

Diagnosis: Date of Diagnosis: ____________
☐ L40.9 Psoriasis
☐ L40.52 Psoriatic Arthritis
☐ Other Diagnosis: ICD-10 Code

Description: ______________________

Has TB test been performed? ☐ Yes ☐ No

Does patient have an active infection? ☐ Yes ☐ No

Start Date: ______________________

Review Date: ______________________

Prescription Information

Medication	Dose/Strength	Directions	Qty	Refills
☐ Cosentyx **NOTE:** For Plaque Psoriasis (6 years or older) For Psoriatic Arthritis (2 years or older)	☐ 75mg/0.5ml Prefilled syringe	**For patients weighting 15 to less than 50kg:** ☐ **Initial:** Inject 75mg SQ weekly at week 0, 1, 2, 3 ☐ **Maintenance:** Inject 75mg SQ on week 4, then every 4 weeks thereafter	4 week supply 4 week supply	0 ________
	☐ 150mg/ml Sensoready pen ☐ 150mg/ml Prefilled syringe	**For patients weighting ≥ 50kg:** ☐ **Initial:** Inject 150mg SQ weekly at week 0, 1, 2, 3 ☐ **Maintenance:** Inject 150mg SQ on week 4, then every 4 weeks thereafter	4 week supply 4 week supply	0 ________
☐ Taltz **NOTE:** For ages 6 to 18 with pediatric Plaque Psoriasis only	☐ 80mg/1ml Prefilled syringe	**For patients weighing < 25kg** ☐ **Initial Dose:** Inject 40mg (0.5ml) SQ at week 0 ☐ **Maintenance:** Inject 20mg (0.25ml) SQ every 4 weeks thereafter	1 SYR 1 SYR	0 ________
	☐ 80mg/1ml Prefilled syringe	**For patients weighing 25 to 50kg** ☐ **Initial Dose:** Inject 80mg SQ at week 0 ☐ **Maintenance:** Inject 40mgn (0.5ml) SQ every 4 weeks thereafter	1 SYR 1 SYR	0 ________
	☐ 80mg/1ml Prefilled syringe ☐ 80mg/1ml Autoinjector	**For patients weighing > 50kg** ☐ **Initial Dose:** Inject 160mg SQ at week 0 ☐ **Maintenance:** Inject 80mg SQ every 4 weeks thereafter	1 SYR/pen 1 SYR/pen	0 ________

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: ______________________ NPI: ______________ DEA: ______________ LIC#: ______________

Address: ______________________

City: ______________________ State: ________ Zip: ____________ Tel: ______________ Fax: ____________

Contact Person: ______________________

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: ______________________ ☐ **Dispense as written (DAW) Date:** ______/______/______

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