Zarina Pharmacy
SPECIALTY & INFUSION

Pediatric Dermatology A-G

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ L20.9 Atopic Dermatitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____

Prior Failed Meds: ☐ Biologics: _____ ☐ Oral: _____
☐ Topical: _____ ☐ Other: _____

Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

		Prescription Information	Qty	Refills
☐ Adbry® *12+ Years Old	150 mg PFS	☐ Load: Inject 300 mg (as two-150 mg injections) SUBQ on Day 1, then inject 150 mg SUBQ every other week starting on Day 15 ☐ Maintenance: Inject 150 mg SUBQ every other week starting on Day 15	2 Syringes 2 Syringes	None _____
☐ Cibinqo™ *12+ Years Old	☐ 50 mg ☐ 100 mg ☐ 200 mg	☐ Take 1 tablet by mouth once daily	30 Tablets	_____
☐ Cosentyx®	☐ 75 mg PFS 150 mg ☐ Pen ☐ PFS	☐ Load: Inject 75 mg SUBQ on week 0, 1, 2, 3 (<50 kg) ☐ Maintenance: Inject 75 mg SUBQ on week 4, then every 4 weeks thereafter (<50 kg) ☐ Load: Inject 150 mg SUBQ on week 0, 1, 2, 3 (≥50 kg) ☐ Maintenance: Inject 150 mg SUBQ on week 4, then every 4 weeks thereafter (≥50 kg)	4 Week Supply 4 Week Supply 4 Week Supply 4 Week Supply	None _____ None _____
☐ Dupixent® *Age 6 Months-5 Years Old	☐ 200 mg PFS w/Shield ☐ 200 mg Pen (2+ years old)	☐ Inject 200 mg SUBQ every 4 weeks (5 kg to <15 kg)	2 Syringes	_____
	☐ 300 mg PFS w/Shield ☐ 300 mg Pen (2+ years old)	☐ Inject 300 mg SUBQ every 4 weeks (15 kg to <30 kg)	2 Syringes	_____
☐ Dupixent® *Age 6-17 Years Old	☐ 300 mg PFS w/Shield ☐ 300 mg Pen	☐ Load: Inject 600 mg (as two-300 mg injections in different sites) on Day 1, then 300 mg every 4 weeks starting on Day 29 (15kg to <30kg) ☐ Maintenance: Inject 300 mg SUBQ once every 4 weeks starting on Day 29 (15 kg to <30 kg)	2 Syringes 2 Syringes	None _____
	☐ 200 mg PFS w/Shield ☐ 200 mg Pen	☐ Load: Inject 400 mg (as two-200 mg injections in different sites) on Day 1, then 200 mg every other week starting on Day 15 (30 kg to <60 kg) ☐ Maintenance: Inject 200 mg SUBQ once every other week starting on Day 15 (30 kg to <60 kg)	2 Syringes 2 Syringes	None _____
	☐ 300 mg PFS w/Shield ☐ 300 mg Pen	☐ Load: Inject 600 mg (as two-300 mg injections in different sites) on Day 1, then 300 mg every other week starting on Day 15 (≥60 kg) ☐ Maintenance: Inject 300 mg SUBQ every other week starting on Day 15 (≥60 kg)	2 Syringes 2 Syringes	None _____
☐ Ebglyss™ *12+ Years Old: ≥40 kg	☐ 250 mg Pen ☐ 250 mg PFS	☐ Initial: Inject 500 mg (as two-250 mg injections) SUBQ at week 0 and week 2 ☐ Induction: Inject 250 mg SUBQ every 2 weeks (weeks 4-14). If additional induction dosing is needed, contact the pharmacy. ☐ Maintenance: Inject 250 mg SUBQ every 4 weeks, starting week 16.	4 Injections 2 Injections 1 Injection	None 2 _____
☐ Enbrel®	50 mg ☐ SureClick® ☐ PFS ☐ Mini ☐ 25 mg PFS ☐ 25 mg/0.5 mL SDV	☐ Inject 50 mg SUBQ once a week (≥63 kg) ☐ Inject 25 mg SUBQ once a week ☐ Inject _____ mg (0.8 mg/kg) subcutaneously once a week (<63 kg)	4 Week Supply 4 Week Supply 4 Week Supply	_____ _____ _____
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**

Zarina Pharmacy
SPECIALTY & INFUSION

Pediatric Dermatology H-O

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ L20.9 Atopic Dermatitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____

Prior Failed Meds: ☐ Biologics: _____ ☐ Oral: _____
☐ Topical: _____ ☐ Other: _____

Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Humira® HS Citrate Free *Adol: 30 kg-59 kg	☐ PsO/UV Starter Pkg (Pens only) 40 mg ☐ Pen ☐ PFS	☐ Load: Inject 80 mg SUBQ on Day 1, then 40 mg on Day 8, then 40 mg every other week thereafter ☐ Maintenance: Inject 40 mg SUBQ every other week	Loading Dose 4 Week Supply	None _____
☐ Humira® HS Citrate Free *Adol: ≥60 kg	☐ HS Starter Pkg (Pens only) 40 mg ☐ Pen ☐ PFS	☐ Load: Inject 160 mg SUBQ as ☐ two-80 mg injections on Day 1 **or** ☐ one-80 mg injection on Day 1 and then Day 2, then inject 80 mg on Day 15, then inject 40 mg every week thereafter starting on Day 29 ☐ Maintenance: Inject 40 mg SUBQ every week	Loading Dose 4 Week Supply	None _____
☐ Humira® HS Citrate Free *HS Adol: ≥6 0kg	☐ HS Starter Pkg (Pens only) ☐ 80 mg Pen	☐ Load: Inject 160 mg SUBQ as ☐ two-80 mg injections on Day 1 **or** ☐ one-80 mg injection on Day 1 and then Day 2, then inject 80 mg on Day 15, then inject 80 mg every other week thereater starting on Day 29 ☐ Maintenance: Inject 80 mg SUBQ every other week	Loading Dose 4 Week Supply	None _____
☐ Litfulo™ *12+ Years Old	50 mg Capsule	☐ Take 1 capsule by mouth once daily	28 Capsules	_____
☐ Nemluvio® *12+ Years Old	30 mg Pen	☐ Load: Inject 60 mg (as two-30 mg pens) SUBQ at week 0 ☐ Maintenance: Inject 30 mg (1 pen) SUBQ every 4 weeks	2 Pens 1 Pen	None _____
☐ Otezla® *20 kg to <50 kg	☐ 10 mg-20 mg Starter Pack ☐ 20 mg Tablet	☐ Take 1 tablet by mouth on Day 1 then twice daily as directed **or** date provided _____ ☐ Take 1 tablet by mouth twice daily For Bridge Requests please utilize the Otezla Support Plus Start Form and fax to BioPlus Specialty Pharmacy at 800-269-5493	1 Starter Pack 60 Tablets	None _____
☐ Otezla® *≥50 kg	☐ 10 mg-20 mg-30 mg Starter Pack ☐ 30 mg Tablet	☐ Take 1 tablet by mouth on Day 1 then twice daily as directed **or** date provided _____ ☐ Take 1 tablet by mouth twice daily For Bridge Requests please utilize the Otezla Support Plus Start Form and fax to BioPlus Specialty Pharmacy at 800-269-5493	1 Starter Pack 60 Tablets	None _____
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

_____ _____ _____ _____

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**

Zarina Pharmacy
SPECIALTY & INFUSION

Pediatric Dermatology P-Z

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ L20.9 Atopic Dermatitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____

Prior Failed Meds: ☐ Biologics: _____ ☐ Oral: _____
☐ Topical: _____ ☐ Other: _____

Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information			Qty	Refills
☐ Rinvoq® *12+ Years Old; ≥40 kg	☐ 15 mg ER Tablet ☐ 30 mg ER Tablet	☐ Take 1 tablet by mouth once daily	30 Tablets	_____
☐ Stelara® Psoriasis	☐ 45 mg Vial (<60 kg)	☐ Starter: Inject _____ mg (0.75 mg/kg) SUBQ on week 0 ☐ Maintenance: Inject _____ mg (0.75 mg/kg) SUBQ on week 4, then every 12 weeks thereafter	1 Vial 1 Vial	None _____
	☐ 45 mg PFS (60 kg to ≤100 kg) ☐ 90 mg PFS (>100 kg)	☐ Starter: Inject 1 syringe SUBQ on week 0 ☐ Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter	1 Syringe 1 Syringe	None _____
☐ Stelara® Psoriatic Arthritis	☐ 45 mg Vial (<60 kg)	☐ Starter: Inject _____ mg (0.75 mg/kg) SUBQ on week 0 ☐ Maintenance: Inject _____ mg (0.75 mg/kg) SUBQ on week 4, then every 12 weeks thereafter	1 Vial 1 Vial	None _____
	☐ 45 mg PFS (≥60 kg) ☐ 90 mg PFS (>100 kg with Ps)	☐ Starter: Inject 1 syringe SUBQ on week 0 ☐ Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter	1 Syringe 1 Syringe	None _____
☐ Taltz®	☐ 40 mg PFS ☐ 20 mg PFS	☐ Starter: Inject 40 mg SUBQ on Day 1 (<25 kg) ☐ Maintenance: Inject 20 mg SUBQ every 4 weeks thereafter (<25 kg)	1 Syringe 1 Syringe	None _____
	☐ 80 mg PFS ☐ 40 mg PFS	☐ Starter: Inject 80 mg SUBQ on Day 1 (25 kg to 50 kg) ☐ Maintenance: Inject 40 mg SUBQ every 4 weeks thereafter (25 kg to 50 kg)	1 Syringe 1 Syringe	None _____
	80 mg ☐ Pen ☐ PFS	☐ Starter: Inject 160 mg (as two-80 mg injections) SUBQ on Day 1 (>50 kg) ☐ Maintenance: Inject 80 mg SUBQ every 4 weeks thereafter (>50 kg)	2 Syringes 1 Syringe	None _____
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) **Substitution Permitted** **Date**

Prescriber's Signature (no stamps) **Dispense As Written** **Date**