



StMatthewsRx.com

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Dermatology

A-N

3922B Willis Ave.
Louisville, KY 40207

Need By Date: / /

SHIP TO: Office

Other

Pharmacy to Inject

PATIENT INFO

PROVIDER INFO

Name: Address: City: State: Zip: Phone: Alt. Phone: Social Security# DOB: Height: Weight: License #
Alternate Contact: Phone: Contact Person: Sp#

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: L40.0 Moderate to Severe Plaque Psoriasis, L40.0 Psoriatic Arthritis, L73.2 Hidradenitis Suppurativa - Hurley Stage:
Location: %BSA: Hands, Feet, Scalp, Groin, Nails, Other: Patient Allergies:
Prior Failed Medications: Cimzia, Cosentyx, Enbrel, Humira, Orencia, Remicade, Simponi, Soriatane, Stelara, Taltz
Methotrexate Length of Treatment: Reason for Discontinuing:
PUVA/UVB Length of Treatment: Reason for Discontinuing:
Topicals Length of Treatment: Reason for Discontinuing:
Contraindicated Medication: Reason:
Inadequate Response (List Specific Names):
Weight: Height: Hepatitis Test Result: Hep B ruled out/treated: Yes No Date:
TB/PPD Test given? Yes No Test Date: Test Results: ISGA score: EASI score: POEM score: SCORAD:

PRESCRIPTION INFORMATION

QUANTITY REFILLS

Table with columns for medication name, dosage/form, initial and maintenance instructions, quantity, and refills. Includes Cimzia, Cosentyx, Dupixent, Enbrel, Humira, and Ilumya.

Prescriber Signature: Dispense as Written (DAW) Today's Date:
I authorize the pharmacy to act as an agent to obtain prior authorization for prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.
If PA denied: Contact office for appropriate step therapy Draft appeal automatically for review

Important Notice: This fax is intended only to the named addressee and contains information that may be protected health information under federal and state laws. If you are not the intended recipient, do not copy, distribute, or disseminate. Please notify sender immediately and destroy this document.

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