RARE SPECIALTY PHARMACY
@RareSpecialtyRx | RareSpecialtyRx.com | #RareSpecialtyRx

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398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____
IDC-10 Diagnosis Code: ❑L40.59 Psoriatic Arthritis ❑L40.0 Psoriasis ❑L20.____ Atopic Dermatitis ❑M35.2 Behçet's Disease ❑Other Diagnosis _____

DERMATOLOGY ORDER FORM

CIBINQO ❑100mg QTY: 30 Refills: ___
SIG: Take 1 tablet by mouth once daily with food (May increase to 200mg if no response after 12 weeks on 100mg, 50mg available for populations requiring dosing adjustments.)

COSENTYX ❑Enroll in *Cosentyx Connect*
❑150mg Sensoready Pen ❑150mg Prefilled Syringe
❑Starter: Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
❑Sig: Inject 300mg dose SQ once weekly for 5 weeks QTY: 10 injection devices Refills: 0
(*Each 300mg dose is given as 2 SQ injections of 150mg*)
❑Sig: Inject 150mg dose SQ once weekly for 5 weeks QTY: 5 injection devices Refills: 0
❑Maintenance: Once every 4 weeks
❑Sig: Inject 300mg dose SQ once every 4 weeks
(*Each 300mg dose is given as 2 SQ injections of 150mg*)
❑Sig: Inject 150mg dose SQ once every 4 weeks
❑1 Month ❑2 Months ❑3 Months QTY: ___ Refills: ___

ENBREL (etanercept) ❑Enroll in *ENBREL Support*
❑SureClick Autoinjector 50mg ❑Prefilled Syringe 50mg
❑Enbrel Mini/AutoTouch 50mg ❑Multiuse Vial 25mg ❑Prefilled Syringe 25mg/0.5ml
❑Psoriasis Induction Dose: Inject 50mg SQ TWICE a week QTY: 8 Refills: 2
(3-4 days apart) for 3 months, then maintenance dosing
❑Psoriasis Maintenance Dose: Inject 50mg SQ ONCE a week QTY: _____ Refills: ___
❑Psoriatic Arthritis Dose: Inject 50mg SQ ONCE a week QTY: _____ Refills: ___
❑Other QTY: _____ Refills: ___

HUMIRA & HUMIRA Citrate-Free ❑Enroll in *Humira Complete*
Adult Psoriasis/Adolescent HS (30kg to <60kg) Starter: Patient weight (kg):_____
❑80mg/0.8ml + 40mg/0.4ml citrate-free Pen Starter Kit (3-ct)
❑40mg/0.8ml Pen Original Starter Kit (4-ct)
Sig: Inject 80mg SQ on Day 1, then inject 40mg SQ on Day 8, then inject 40mg SQ every other week. QTY: 1 kit Refills: 0
Adult HS Starter:
❑80mg/0.8ml citrate-free Pen Hidradenitis Suppurativa Starter Kit (3-ct)
❑40mg/0.8ml Pen Hidradenitis Suppurativa Starter Kit (6-ct)
SIG: Inject 160mg SQ on Day 1, then inject 80mg SQ on Day 15. QTY: 1 Kit Refills: 0
Maintenance: ❑40mg/0.4ml citrate-free Pen (2-ct) ❑40mg/0.4ml citrate-free PFS (2-ct)
❑40mg/0.8ml P ❑40mg/0.8ml PFS (2-ct)
❑Adult Psoriasis/Adolescent HS Sig: Inject 40mg SQ every other week.
❑Adult Hidradenitis Suppurativa Sig: Inject 40mg SQ every week starting on Day 29.
❑Other: _____ QTY: _____ Refills: _____

OTEZLA ❑Enroll in *Otezla SupportPlus*
Prescriber provided Two-Week Starter Pack on _____ ❑Enroll in *BridgeRx Program*
❑Starter: 28 Day Starter Pack SIG: Take as directed QTY: 55 Refills: ___
❑30mg twice daily (recommended) ❑30mg daily (for severe renal impairment)
❑Maintenance: SIG: Take one tablet by mouth twice daily QTY: 60 Refills: ___
❑Maintenance: SIG: Take one tablet by mouth daily QTY: 30 Refills: ___

REMICADE ❑Enroll in *Janssen CarePath*
❑100mg Vial QTY: __ # of vials Refills: __
❑ Induction: Infuse 5mg/kg in 250mL of 0.9% NaCl at wks 0,2,6, & every 8 wks thereafter
❑Maintenance: Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 wks
❑Other: _____

SILIQ ❑210mg/1.5 mL PFS ❑Enroll in *Siliq Solutions*
❑ Induction Dose: Inject 210 mg of SILIQ at Weeks 0, 1, and 2 then maint. QTY: 3 Refills: ___
❑ Maintenance Dose: Inject 210 mg of SILIQ every 2 weeks QTY: 2 Refills: ___

TALTZ 80mg ❑Autoinjector ❑Prefilled Syringe ❑Enroll in *Taltz Together*
❑Starting: Inject 160mg SQ at wk 0 followed by 80mg at wks 2,4,6,8,10 & 12 QTY: 8 Refills 0
❑Maintenance: Inject 80mg SQ every 4 weeks QTY: ___ Refills: ___
❑Other: _____ QTY: ___ Refills: ___

OTHER:_____ SIG:_____ QTY:_____ Refills:_____

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

CIMZIA 200mg/mL ❑PFS 2-ct pack ❑PFS 6-ct Starter Kit ❑Enroll in *CIMplicity*
Psoriasis: ❑Starter: Inject 400mg SQ every other week QTY: 2 Packs Refills: 0
< 90kg, may consider: ❑Starter: Inject 400mg SQ at weeks 0, 2, and 4 QTY: 1 Kit Refills: 0
❑Maintenance: Inject 200mg SQ every other week thereafter QTY: 1 Pack Refills: ___
Psoriatic Arthritis: ❑Starter: Inject 400mg SQ at week 0, 2, and 4 QTY: 1 Kit Refills: ___
❑Maintenance: Inject 200mg SQ every other week QTY: 1 Pack Refills: ___
❑Maintenance: Inject 400mg SQ every four weeks QTY: 1 Pack Refills: ___

DUPIXENT ❑Enroll in *MyWay*
❑300mg/2mL PFS ❑300mg/2mL Pen Injector ❑200mg/1.14mL PFS
❑Adolescent Starter (<60kg):
Inject 400mg SQ on Day 1, then inject 200mg SQ every other week. QTY: 4 PFS Refills: 0
❑Adolescent Maintenance: Inject 200mg SQ every other week. QTY: 2 PFS Refills: ___
❑Adolescent Starter (>60kg):
Inject 600mg SQ on Day 1, then inject 300mg SQ every other week. QTY: ___ Refills: 0
❑Adolescent Maintenance: Inject 300mg SQ every other week. QTY: ___ Refills: ___
❑Adult Starter:
Inject 600mg SQ on Day 1, then inject 300mg SQ every other week. QTY: ___ Refills: 0
❑Adult Maintenance: Inject 300mg SQ every other week. QTY: ___ Refills: ___

ERIVEDGE 150mg QTY: 28 Refills: ___
❑SIG: Take 1 capsule by mouth once daily.
ZELBORAF 240mg QTY: 224 Refills: ___
❑SIG: Take 4 tablets by mouth twice daily approximately 12 hours apart with or without a meal.
COTELLIC 20mg QTY: 63 Refills: ___
❑SIG: Take 3 tablets by mouth once daily for the first 21 days of each 28 day cycle.

ILUMYA Prefilled Syringe 100mg/mL ❑Enroll in *Ilumya Support*
❑Starter: Initial dose of 100mg SQ injection at week 0 and week 4
❑Maintenance: 100mg SQ injection given every 12 weeks thereafter. QTY: _____ Refills: ___

RASUVO ❑Enroll in *CORE Connections*
❑10mg ❑12.5mg ❑15mg ❑17.5mg ❑20mg ❑22.5mg ❑25mg
❑Inject _____mg subcutaneously weekly QTY: 4 Refills: ___

RINVOQ tablets ❑15mg ❑30mg QTY: ___ Refills: ___
❑Atopic Dermatitis: 15mg once daily, may increase to 30mg once daily if inadequate response
❑Psoriatic Arthritis: 15mg once daily

SIMPONI ❑SmartJect Autoinjector ❑PFS 50mg/0.5mL Patient Weight (kg):___
❑Psoriatic Arthritis Dose: Inject 50 mg (0.5ml) SQ once a month QTY: 1 vial Refills: ___
❑Other: _____ QTY: _____ Refills: ___
SIMPONI ARIA ❑50mg/4ml (12.5mg/ml) in a single use vial QTY: 1 vial Refills: ___
Dose: 2mg/kg intravenous infusion over 30 minutes at wks 0 & 4, then every 8 wks
❑Enroll in *SimponiOne*

Skyrizi 150mg/mL ❑PFS ❑PEN ❑Enroll in *Skyrizi Complete*
❑Starter Dose: Inject 150mg SQ at week 0, week 4 QTY: 2 Refills: 0
❑Maintenance Dose: Inject 150mg SQ ever 12 weeks thereafter QTY: _____ Refills: ___

STELARA *patient weight (kg):*_____ ❑Enroll in *Janssen CarePath*
❑45mg/0.5mL PFS (*for pts weighing <100kg (220lbs)*
❑Starting Dose: Inject 45mg (1 PFS) SQ initially QTY: 1 PFS Refills: 0
Inject 45mg (1 PFS) SQ 4 weeks later QTY: 1 PFS Refills: 0
❑Maintenance Dose: Inject 45mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refills: _____
❑90mg/mL PFS (*for pts weighing >100kg (220lbs)*
❑Starting Dose: Inject 90mg (1 PFS) SQ initially QTY: 1 PFS Refills: 0
Inject 90mg (1 PFS) SQ 4 weeks later QTY: 1 PFS Refills: 0
❑Maintenance Dose: Inject 90mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refills: _____
❑Other: _____ QTY: _____ Refills: _____

TREMFYA ❑Enroll in *Janssen CarePath*
❑Prefilled Syringe 100mg/mL ❑One-Press Injector 100mg/mL
❑Starting: Initial dose of 100mg SQ injection at week 0 and week 4
❑Maintenance: 100mg SQ injection given every 8 weeks thereafter. QTY: ___ Refills: ___

Prescriber Name/Practice: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____ Date: _____