MID-WEST SPECIALTY PHARMACY

Dermatology Prior Authorization Form

PHONE: (888)544-1111 FAX:(424)777-0888

PATIENT INFORMATION

SHIP TO: ☐ Patient ☐ Office - First Dose ☐ Office - All Doses ☐ Other:

Patient Name	DOB	SS#
Address	City	State Zip
Phone #	Alt Phone #	
Sex: ☐ Male ☐ Female ☐ other:	Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ other:	

PLEASE FAX A COPY OF BOTH SIDES OF PATIENT'S INSURANCE, MEDICAID OR MEDICARE PART D CARD

CLINICAL INFORMATION

Diagnosis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage ______
☐ Other: DX Code:

Location: % BSA: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other:

Allergies	Hepatitis Test Result	TB/PPD Test Needed? ☐ Yes ☐ No	Test Result
Patient Weight	Contraindicated Medication	Reason:	

Inadequate Response: List Specific Names:

Previous Therapies:

☐ Cimzia ☐ Cosentyx ☐ Cyclosporine ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Rituxan ☐ Simponi ☐ Stelara ☐ Soriatane

Medication	Length of Treatment	Reason for Discontinuing
☐ Medication: Methotrexate	Length of Treatment:	Reason for Discontinuing:
☐ Medication: PUVA/UVB	Length of Treatment:	Reason for Discontinuing:
☐ Medication: Topicals	Length of Treatment:	Reason for Discontinuing:

PRESCRIPTION INFORMATION

PRESCRIPTION: ☐ below ☐ sent separately ☐ phoned in ☐ e-prescribed

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cosentyx®	☐ 150mg SensorReady Pen ☐ 300mg (150mg x 2) Pen ☐ Prefilled Syringe	Inject 150mg subcutaneously at weeks 0, 1, 2, 3, and 4, then every 4 weeks thereafter Inject 300mg subcutaneously at weeks 0, 1, 2, 3, and 4, then every 4 weeks thereafter Inject 150mg subcutaneously every 4 weeks ☐ Inject 300mg SQ every 4 weeks	4 Week Supply	____
☐ Enbrel®	☐ 50mg Sureclick ☐ 50mg Prefilled Syringe ☐ 25mg PFS or ☐ Vials	Inject 50mg subcutaneously TWICE a week 72-96 hours apart Inject 50mg subcutaneously ONCE a week Inject 25mg subcutaneously TWICE a week 72-96 hours apart	4 Week Supply	____
☐ Humira®	☐ Psoriasis Starter Kit ☐ 40mg Pen ☐ 40mg Prefilled Syringe	Inject 2-40mg (80mg) on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Inject 40mg subcutaneously every OTHER week ☐ Inject 40mg subcutaneously ONCE a week	Loading Dose 4 Week Supply	____
☐ Humira® HS	☐ HS Starter Kit ☐ 40mg Pen ☐ 40mg Prefilled Syringe	160mg given as ☐ Four 40mg SubQ day 1 OR ☐ Two 40mg SubQ days 1 & then Week 2 inject 80mg (Two 40mg injections) subcutaneously on day 15 ☐ Day 29+ inject 40mg subcutaneously ONCE a week	4 Week Supply	____
☐ Otezla®	☐ Starter Pack ☐ 30mg Tablets	☐ Titrate: Take 1 tablet on day 1 then twice daily as directed OR date provided ______ ☐ Maintenance: Take 1 tablet by mouth ONCE daily. ☐ Maintenance: Take 1 tablet by mouth TWICE daily.	1 Starter Pack 30 60	____
☐ Otezla® Bridge RX	30mg Tablets	☐ Bridge Rx: Take 1 tablet by mouth TWICE daily; dispensed by OSP (recommended daily dose) ☐ Bridge Rx: Take 1 tablet by mouth ONCE daily; dispensed by OSP (for patients with severe renal impairment)	28	6 12
☐ Simponi®	☐ 50mg SmartJect or ☐ PFS ☐ Aria	Inject 50mg subcutaneously ONCE a MONTH as directed Infuse______mg at weeks 0 and 4, then every 8 weeks thereafter	4 Week Supply	____
☐ Stelara®	☐ 45mg Prefilled Syringe ☐ 90mg Prefilled Syringe	Inject 45mg on day 0, then week 4, then every 12 weeks (Patients < 220lbs) Inject 90mg on day 0, then week 4, then every 12 weeks (Patients > 220lbs)	4 Week Supply	____
☐ Other			4 Week Supply	____

PRESCRIBER INFORMATION

PREFERRED CONTACT METHOD: ☐ Phone ☐ Fax ☐ Email

Prescriber Name	Type: ☐ MD/DO ☐ Nurse Practitioner ☐ Physician's Assistant	
Office Contact	Supervising Prescriber (if applicable)	
Phone #	Fax #	Email
Address	City	State Zip
NPI	DEA	

Statement of medical necessity: I certify the prescribed therapy is medically necessary. I will be supervising the patient treatment accordingly and all information is accurate to the best of my knowledge. I authorized Mid-West Pharmacy as my designated agent on behalf of my patient to (1) Provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above name patient.

Prescriber Signature______________________________ Date________________