METIER PHARMACY CO.
Pharmacy Unscripted

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Ship To: ☐Patient ☐Physician/Clinic Date Shipment Needed: **Rx:** ☐New ☐Refill

PATIENT INFORMATION

Patient's Full Name:
Address: _____
City, State, Zip:
Home Phone:
Alt. Phone:
Patient SS#:
DOB: _____ Gender: ☐Male ☐Female
Allergies: _____
Insurance: _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

PRIOR (FAILED) MEDICATION:

	Medication	Reasons for Discontinuation
☐Biologics/MTX:		
☐PUVA/UVB/Others:		

Diagnosis: **ICD-10 Code:** _____
☐L40.0 Psoriasis ☐L40.5 Psoriatic Arthritis ☐L73.2 Hidradenitis suppurativa
Other: Date of Diagnosis: OR Years With Disease

Medical Assessment (Within Last 12 Months):
- Psoriasis Severity: ☐Moderate ☐Moderate to Severe ☐Severe
- Psoriasis Type: ☐Plaque ☐Other (please specify)

Patient Evaluation:
- Has patient been diagnosed with Lymphoma? ☐Yes ☐No
- Does patient have serious/active infection? ☐Yes ☐No
- Has TB test been performed? ☐Yes ☐No
  If yes, result: _____
  Comments: _____
- Has Hepatitis B been ruled out or treatment been iniated? ☐Yes ☐No
  If NO, has treatment been initiated? ☐Yes ☐No
- Does patient have a latex allergy? ☐Yes ☐No
- Is patient's platelet count >52,000 cell/uL? ☐Yes ☐No
- Patient Weight: kg/lbs ☐Yes ☐No

Patient Evaluation Cont
_____ BSA
% affected by Psoriasis
Front Back

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY.	REFILLS
☐ **Otezla**	☐Titration Pack or Date starter pack was provided ____/____/_____ ☐30 mg ☐Bridge RX	☐Take as instructed according to the package instructions presented for 28 days ☐1 tablet twice daily	#55 #60	
☐ **Cosentyx**	☐150 mg/mL Sensoready pen ☐150 mg/mL Pre-filled syringe ☐150 mg Lyophilized powder SDV	☐Induction Dose: 300 mg subq at Weeks 0, 1, 2, 3, and 4 ☐Maintenance Dose: 300 mg subq every 4 weeks		
☐ **Enbrel**	☐50 mg/ml Sureclick Autoinjector ☐50 mg/ml Prefilled Syringe ☐25 mg/0.5ml Prefilled Syringe ☐25 mg Vial	☐Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing ☐Maintenance Dose: Inject 50mg SC ONCE a week ☐Other:		
☐ **Humira**	☐40 mg/0.8ml Pen ☐40 mg/0.8ml Prefilled Syringe	☐**Psoriasis Induction Dose:** Inject two 40mg pens/syringes SC on day 1, then one 40mg pen/syringe on day 8, then one 40mg pen every other week ☐Maintenance Dose: Inject one 40mg pen/syringe SC every other week ☐**Hidradenitis Induction Dose:** Inject four 40mg pens/syringes SC on day 1, then two 40mg pens/syringes on day 15, then one 40mg pen every week starting day 29 ☐Maintenance Dose: Inject one 40mg pen/syringe SC every week		
☐ **Stelara**	☐45 mg/ml Syringe ☐90 mg/ml Syringe	☐For patients weighing <100kg (220lbs): inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks. ☐For patients weighing>100kg (220lbs): Inject 90mg (two 45mg vials) SC initially and 4 weeks later, followed by 90mg every 12 weeks		

Primary ICD-10: ☐BRAF V600E ☐BRAF V600K

☐ **Mekinist** ☐0.5 mg ☐1 mg ☐2 mg daily **Qty:** ☐Other **Refill:**

☐ **Tafinlar** ☐50 mg ☐75 mg **Qty:**_____ **Refill:** _____
Take capsules by mouth time(s) a day

☐ **Zelboraf** ☐240 mg **Qty:** _____ **Refill:**
Take _____ capsules by mouth _____ time(s) a day

☐ **Erivedge** ☐150 mg Daily **Qty:** _____ **Refill:** _____
☐Other

Has treatment started: ☐Yes ☐No Date:

Please complete the following appropriately:
Metastic basal cell carcinoma ☐Yes ☐No **OR** Locally advanced basal cell carcinoma recurred following surgery or not candidate for surgery ☐Yes ☐No

Previous Treatments:
☐None ☐Surgery ☐Radiation ☐Chemotherapy ☐Other:

"I give permission for my health care providers, Metier Pharmacy, and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical conditions, medical records and health ("Personal Information") to Metier Pharmacy, its affiliates, business partners, and agents to that Metier Pharmacy can verify or coordinate insurance coverage for my prescribed therapy." Signature: _____

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____
Address: _____ License#: _____
City, State, Zip: _____ DEA#: _____
Phone: _____ Fax: _____ Contact Name: _____
Physician's Signature: _____ Date: _____

I authorize Metier Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

-This prescription form is valid only if faxed directly by the prescriber or his/her authorized representative. Original prescription drug orders can only be accepted directly from the patients.
-The prescriber attests that he/she has advised the patient with the option of choosing a pharmacy of his/her choice.