MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

DERMATOLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:		Secondary Insurance:	
ID#:	RxBin:	ID#:	RxBin:
RxGroup:	Pcn:	RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ AKLIEF	☐ .005% CREAM	☐ APPLY A THIN LAYER OF CREAM TO AFFECTED AREAS ONCE DAILY IN THE EVENING, ON CLEAN AND DRY SKIN	[45] gram pump	
☐ ALTRENO	☐ .05% LOTION	☐ APPLY A THIN LAYER OF LOTION TO AFFECTED AREAS ONCE DAILY	[20] or [45] gram bottle	
☐ AMZEEQ	☐ 4% FOAM	☐ APPLY TO AFFECTED AREAS ONCE DAILY	[30] gram can	
☐ ARAZLO	☐ .045% LOTION		[45] gram bottle	
☐ BIMZELX	☐ 160MG PFS ☐ 160MG AUTOINJECTOR ☐ 320MG PFS ☐ 320MG AUTOINJECTOR	☐ INJECT____MG SQ EVERY____WEEKS, FOR____WEEKS	[QS 4 WEEK SUPPLY]	
☐ BRYHALI	☐ .01% LOTION	☐ APPLY A THIN LAYER OF LOTION TO AFFECTED AREAS ONCE DAILY	[60] or [100] gram tube	
☐ CABTREO	☐ 1.2%/.15%/3.15% GEL	☐ APPLY A THIN LAYER OF GEL TO AFFECTED AREAS ONCE DAILY	[50] gram pump	
☐ CIBINQO	☐ 50MG TABLET ☐ 100MG TABLET ☐ 200MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ CIMZIA	☐ 200MG PFS ☐ 200MG SDV	☐ INJECT____MG SQ EVERY____WEEKS, FOR____WEEKS	[QS 4 WEEK SUPPLY]	

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ COSENTYX	☐ 150MG PFS ☐ 150MG PEN ☐ 300MG PFS ☐ 300MG PEN	☐ INJECT_____MG SQ EVERY_____WEEKS, FOR_____WEEKS	[QS 4 WEEK SUPPLY]	
☐ DENAVIR	☐ 1% CREAM	☐ APPLY CREAM EVERY 2 HOURS DURING WAKING HOURS FOR A PERIOD OF 4 DAYS	[5] gram tube	
☐ DUOBRII	☐ .01%/.045% LOTION	☐ APPLY A THIN LAYER OF LOTION TO AFFECTED AREAS ONCE DAILY	[100] gram tube	
☐ DUPIXENT	☐ 200MG PFS ☐ 200MG AUTOINJECTOR ☐ 300MG PFS ☐ 300MG AUTOINJECTOR	☐ INJECT_____MG SQ EVERY_____WEEKS, FOR_____WEEKS	[QS 4 WEEK SUPPLY]	
☐ DRYSOL	☐ 20% DAB-O-MATIC DEVICE ☐ 20% SOLUTION	☐ APPLY A THIN LAYER ONCE DAILY USING THE PROVIDED APPLICATOR OR A COTTON BALL	35ml device 60ml device	
☐ EBGLYSS	☐ 250MG PFS ☐ 250MG PEN	☐ INJECT_____MG SQ EVERY_____WEEKS, FOR_____WEEKS	[QS 4 WEEK SUPPLY]	

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PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ ENBREL	☐ 25MG SDV ☐ 25MG PFS ☐ 50MG AUTOINJECTOR ☐ 50MG PFS ☐ 50MG MINI CARTRIDGE	☐ INJECT_____MG SQ EVERY_____WEEKS, FOR_____WEEKS	[QS 4 WEEK SUPPLY]	
☐ ENSTILAR	☐ .005%/.064% FOAM	☐ APPLY FOAM TO AFFECTED AREA(S) ONCE DAILY FOR UP TO 4 WEEKS	[60] or [120] gram can	
☐ EUCRISA	☐ 2% OINTMENT	☐ APPLY A THIN LAYER TWICE DAILY TO AFFECTED AREAS	[60] or [100] gram tube	
☐ HUMIRA CF	☐ 40MG PFS ☐ 40MG PEN ☐ 80MG PFS ☐ 80MG PEN	☐ INJECT_____MG SQ EVERY_____WEEKS, FOR_____WEEKS	[QS 4 WEEK SUPPLY]	
☐ ILUMYA	☐ 100MG PFS	☐ INJECT 100 MG SQ AT WEEKS 0, 4, AND EVERY 12 WEEKS THEREAFTER	[QS 4 WEEK SUPPLY]	
☐ ISOTRETINOIN (please specify brand preference)_____	☐ 10MG CAPSULE ☐ 20MG CAPSULE ☐ 30MG CAPSULE ☐ 40MG CAPSULE			

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ JUBLIA	☐ 10% SOLUTION	☐ APPLY TO AFFECTED TOENAILS ONCE DAILY USING THE INTEGRATED FLOW-THROUGH BRUSH APPLICATOR	[4] or [8] ML SOLUTION	
☐ KLISYRI	☐ 1% OINTMENT	☐ APPLY OINTMENT TO THE TREATMENT FIELD ON THE FACE OR SCALP ONCE DAILY FOR 5 CONSECUTIVE DAYS USING 1 UNIT-DOSE PACKET PER APPLICATION	[5] UNIT DOSE PACKETS	
☐ ODOMZO	☐ 200MG CAPSULE	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ ONEXTON	☐ 1.2%/3.75% GEL	☐ APPLY A PEA-SIZED AMOUNT GEL TO THE FACE ONCE DAILY	[50] gram pump	
☐ OPZELURA	☐ 1.5% CREAM	☐ APPLY A THIN LAYER OF CREAM TOPICALLY TWICE DAILY TO AFFECTED AREAS OF UP TO 20% BODY SURFACE AREA ☐ APPLY A THIN LAYER OF CREAM TOPICALLY TWICE DAILY TO AFFECTED AREAS OF UP TO 10% BODY SURFACE AREA	[60] gram tube	
☐ OTEZLA	☐ STARTER PACK ☐ 20MG TABLET ☐ 30MG TABLET	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN ☐ TAKE____MG BY MOUTH____TIME(S) PER DAY		
☐ OTEZLA XR	☐ STARTER PACK ☐ 75MG TABLET	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN ☐ TAKE____MG BY MOUTH____TIME(S) PER DAY		
☐ RHAPSIDO	☐ 25MG TABLET	☐ TAKE 1 TABLET BY MOUTH TWICE DAILY	60 Tablets	
☐ RHOFADE	☐ 1% CREAM	☐ APPLY A PEA-SIZED AMOUNT OF CREAM, ONCE DAILY IN A THIN LAYER TO COVER THE ENTIRE FACE	[30] gram tube	
☐ RINVOQ	☐ 15MG ER TABLET ☐ 30MG ER TABLET	☐ TAKE_____MG BY MOUTH ONCE DAILY	[30]	

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PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ SILIQ	☐ 210MG PFS	☐ LOAD: INJECT 210MG SUBCUTANEOUSLY ON WEEKS 0, 1, AND 2, THEN EVERY 2 WEEKS THEREAFTER ☐ MAINTENANCE: INJECT 210MG SUBCUTANEOUSLY EVERY 2 WEEKS	[QS 4 WEEK SUPPLY]	
☐ SIVEXTRO	☐ 200MG TABLET ☐ 200MG SDV		[6]	
☐ SEYSARA	☐ 60MG TABLET ☐ 100MG TABLET ☐ 150MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY		
☐ SIMPOINI	☐ 50MG PFS ☐ 50MG SMARTJECT	☐ INJECT 50MG SUBCUTANEOUSLY ONCE A MONTH AS DIRECTED	[QS 4 WEEK SUPPLY]	
☐ SKYRIZI	☐ 150MG PFS ☐ 150MG PEN	☐ STARTER: INJECT 150MG SUBCUTANEOUSLY ON WEEK 0 ☐ MAINTENANCE: INJECT 150MG SUBCUTANEOUSLY ON WEEK 4, THEN EVERY 12 WEEKS THEREAFTER	[QS 4 WEEK SUPPLY]	
☐ SOTYKTU	☐ 6MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY		
☐ STELARA	☐ 45MG VIAL ☐ 45MG PFS ☐ 90MG PFS	☐ STARTER: INJECT ____MG SUBCUTANEOUSLY ON WEEK 0 ☐ MAINTENANCE: INJECT ____MG ON WEEK 4, THEN EVERY 12 WEEKS THEREAFTER	[QS 4 WEEK SUPPLY]	
☐ TALTZ	☐ 80MG PFS ☐ 80MG AUTOINJECTOR	☐ INJECT____MG SQ EVERY____WEEKS	[QS 4 WEEK SUPPLY]	

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Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ TWYNEO	☐ 0.1%/3% CREAM	☐ APPLY A THIN LAYER OF CREAM TO AFFECTED AREAS ONCE DAILY	[30] gram pump	
☐ TREMFYA	☐ 100MG PFS ☐ 100MG ONE TOUCH INJECTOR	☐ STARTER: INJECT 100MG SUBCUTANEOUSLY ON WEEK 0 ☐ MAINTENANCE: INJECT 100MG SUBCUTANEOUSLY ON WEEK 4, THEN EVERY 8 WEEKS THEREAFTER	[QS 4 WEEK SUPPLY]	
☐ VTAMA	☐ 1% CREAM	☐ APPLY A THIN LAYER OF CREAM TO AFFECTED AREAS ONCE DAILY	[60] gram tube	
☐ WINLEVI	☐ 1% CREAM	☐ APPLY A THIN LAYER (APPROXIMATELY 1 GRAM) TO AFFECTED AREA TWICE DAILY (MORNING AND EVENING)	[60] gram tube	
☐ WYNZORA	☐ .005%/.064% CREAM	☐ APPLY CREAM TO AFFECTED AREAS ONCE DAILY FOR UP TO 8 WEEKS	[60] gram tube	
☐ XELJANZ	☐ 5MG TABLET ☐ 11MG XR TABLET	☐ TAKE_____TABLET(S) BY MOUTH_____DAILY		
☐ YCANTH	☐ .7% SOLUTION	☐ TO BE ADMINISTERED BY HCP	1 KIT	
☐ ZILXI	☐ 1.5% FOAM	☐ APPLY FOAM OVER ALL AREAS OF THE FACE ONCE DAILY	[30] gram can	
☐ ZELSUVMI	☐ 10.3% GEL	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN	1 KIT	
☐ ZORYVE	☐ .05% CREAM ☐ .15% CREAM ☐ .3% CREAM ☐ .3% FOAM	☐ APPLY TO AFFECTED AREAS ONCE DAILY	60 GRAMS	

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