



Fax the completed form to  
**(818) 236-2504**

**Questions? Call (818) 236-2500**  
Monday to Friday, 10 am to 6 pm

**E-prescribing? Send to Foothill Remedy Drugs**  
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

## 1 Patient

Or attach a patient face sheet

Last name \_\_\_\_\_ First name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Sex ☐ F ☐ M ☐ X Height \_\_\_\_\_ Weight \_\_\_\_\_ ☐ kg ☐ lb Allergies ☐ None known \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Cell phone \_\_\_\_\_ Other phone \_\_\_\_\_ Email \_\_\_\_\_  
Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other \_\_\_\_\_

## 2 Insurance

Or attach copies of the cards, front and back

Primary plan \_\_\_\_\_ Member ID \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_  
Secondary plan \_\_\_\_\_ Member ID \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

## 3 Prescriber

Prescriber name \_\_\_\_\_ NPI \_\_\_\_\_ License # \_\_\_\_\_  
Practice \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Office contact \_\_\_\_\_  
Contact phone \_\_\_\_\_ Contact email \_\_\_\_\_

## 4 Clinical information

Please attach recent labs and notes

Diagnosis (ICD-10) ☐ L40.0 Plaque psoriasis ☐ L20.9 Atopic dermatitis ☐ L73.2 Hidradenitis suppurativa  
☐ L28.1 Prurigo nodularis ☐ L50.1 Chronic urticaria ☐ Other \_\_\_\_\_  
Body surface area \_\_\_\_\_ % Severity score (PASI, EASI or IGA) \_\_\_\_\_ ☐ Face, hands, feet or genitals involved  
Tried before ☐ Topical steroids ☐ Other topicals ☐ Phototherapy ☐ Methotrexate ☐ Cyclosporine ☐ Other \_\_\_\_\_  
Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from \_\_\_\_\_  
Reason for switching \_\_\_\_\_  
TB test ☐ Negative ☐ Positive Date \_\_\_\_\_ Hepatitis B screen ☐ Negative ☐ Positive ☐ Not done  
Current medications ☐ List attached \_\_\_\_\_

## 5 Delivery

Needed by \_\_\_\_\_ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy  
Delivery is free within 25 miles of our Tujunga store.

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

## 6 Prescription

Check each medication to fill. Directions and quantity can be changed.

☐ **New start: also dispense the loading doses in each checked drug's label**

| Medication                                                                                       | Strength               | Directions                                         | Quantity   | Refills |
|--------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------|------------|---------|
| <b>Psoriasis and hidradenitis suppurativa</b>                                                    |                        |                                                    |            |         |
| <input type="checkbox"/> <b>Humira</b><br>adalimumab                                             | 40 mg/0.4 mL pen       | Inject 40 mg subcut every other week               | 2 pens     |         |
| <input type="checkbox"/> <b>Adalimumab biosimilar</b><br>the plan's preferred biosimilar         | 40 mg pen              | Inject 40 mg subcut every other week               | 2 pens     |         |
| <input type="checkbox"/> <b>Enbrel</b><br>etanercept                                             | 50 mg/mL SureClick     | Inject 50 mg subcut once weekly                    | 4 pens     |         |
| <input type="checkbox"/> <b>Cimzia</b><br>certolizumab pegol                                     | 200 mg/mL syringe      | Inject 400 mg (2 syringes) subcut every other week | 4 syringes |         |
| <input type="checkbox"/> <b>Stelara</b><br>ustekinumab; 90 mg if over 100 kg                     | 45 mg or 90 mg syringe | Inject 45 mg subcut every 12 weeks                 | 1 syringe  |         |
| <input type="checkbox"/> <b>Ustekinumab biosimilar</b><br>plan's preferred; 90 mg if over 100 kg | 45 mg or 90 mg syringe | Inject 45 mg subcut every 12 weeks                 | 1 syringe  |         |
| <input type="checkbox"/> <b>Tremfya</b><br>guselkumab                                            | 100 mg/mL pen          | Inject 100 mg subcut every 8 weeks                 | 1 pen      |         |
| <input type="checkbox"/> <b>Skyrizi</b><br>risankizumab-rzaa                                     | 150 mg/mL pen          | Inject 150 mg subcut every 12 weeks                | 1 pen      |         |
| <input type="checkbox"/> <b>Bimzelx</b><br>bimekizumab-bkzx                                      | 160 mg/mL pen          | Inject 320 mg (2 pens) subcut every 8 weeks        | 2 pens     |         |
| <input type="checkbox"/> <b>Ilumya</b><br>tildrakizumab-asmn (given in the office)               | 100 mg/mL syringe      | Inject 100 mg subcut every 12 weeks in the office  | 1 syringe  |         |
| <input type="checkbox"/> <b>Sotyktu</b><br>deucravacitinib                                       | 6 mg tablet            | Take 1 tablet by mouth once daily                  | 30 tablets |         |

### Atopic dermatitis, prurigo nodularis and chronic urticaria

|                                                       |                 |                                       |        |  |
|-------------------------------------------------------|-----------------|---------------------------------------|--------|--|
| <input type="checkbox"/> <b>Dupixent</b><br>dupilumab | 300 mg/2 mL pen | Inject 300 mg subcut every other week | 2 pens |  |
|-------------------------------------------------------|-----------------|---------------------------------------|--------|--|

### Other medication (write in)

☐ \_\_\_\_\_

☐ \_\_\_\_\_

## 7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature \_\_\_\_\_ Date \_\_\_\_\_

☐ Do not substitute Prescriber initials \_\_\_\_\_ California law requires the prescriber to initial this box to prevent substitution.