Dermatology Enrollment Form

Fax: 909-284-9140
Phone: 909-266-0016

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____
Address_____
Address 2 _____
City, State, Zip _____
Home Phone_____Mobile Phone _____
DOB_____Last Four of SS_____Gender_____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA_____
NPI _____
Address_____
City, State, Zip _____
Phone_____Fax_____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis / ICD 10: | % of BSA affected? | TB/PPD Test □ Yes □ No Results

□ Psoriasis □ Psoriatic Arthritis □ Chronic Idiopathic Urticaria □ Hidradenitis Suppurativa □ Other

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ Cimzia	□ Starter kit □ 200mg/ml PFS □ 200mg lyophilized vial	□ 400mg SQ weeks 0, 2, 4 □ 200mg SQ every 2 weeks □ 400mg SQ every 4 weeks	□ 1 kit □ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Cosentyx	□ 150mg prefilled Syringe □ 150mg Sensoready Pen	□ 300mg SQ at weeks 0, 1, 2, 3, & 4 followed by 300mg SQ every 4 weeks (PSO) □ 300mg SQ every 4 weeks □ 150mg SQ at weeks 0, 1, 2, 3, & 4 followed by 300mg SQ every 4 weeks (PSA) □ 150mg SQ every 4 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Enbrel	□ 25mg/ml □ 50mg/ml Sureclick autoinjector □ 50mg/ml PFS □ 50 mg Mini Cartridge	□ 25mg SQ once weekly □ 50mg SQ twice weekly for 3 months □ 50mg SQ once weekly	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Humira CF	□ Psoriasis Starter pack □ 40mg/0.4ml pen □ 40mg/0.4ml PFS □ 80mg/0.4mg pen □ Crohn/ UC/ HS Starter pack	□ Inject 40mg SQ every other week □ Inject 40mg SQ once weekly □ Inject 80 mg SQ every other week □ Inject 80mg SQ on day 1 then inject 40mg on day 8 then inject 40mg every other week thereafter (Psoriasis Starter pack) □ Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose (Crohn's/HS Starter pack)	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Ilumya	□ 100mgl prefilled syringe	□ 100mg SQ at weeks 0 & 4 followed by 100 mg every 12 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Otezla	□ Starter Pack □ 30mg tablets	□ Take are directed □ Take 30mg PO twice daily □ Take 30mg PO once daily	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Siliq	□ 210mg/1.5ml PFS	□ 210mg SQ at weeks 0, 1, & 2 followed by 210mg every 2 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Simponi	□ 50mg/0.5ml SmartJect autoinjector □ 50mg/0.5ml PFS	□ Inject 50mg SQ every 4 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Skyrizi	□ 75mg/0.83mL prefilled syringe	□ Inject 150mg SQ at week 0, 4, and every 12 weeks thereafter □ Inject 150mg SQ every 12 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Stelara	□ 45mg/0.5ml PFS □ 90mg/0.5ml PFS	□ Inject 1 syringe SQ on days 0 and 28 (starter dose) □ Inject 1 syringe SQ every 12 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Taltz	□ 80mg Auto-Injector Starter Kit (3 pens) □ 80mg Auto-Injector (2 pens) □ 80mg Auto-Injector (1 pen) □ 80mg Prefilled Syringe (1 syringe)	□ 160mg SQ on day 1, then followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, and then 80mg every 4 weeks □ 80mg SQ every 4 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Tremfya	□ 100mg PFS □ 100mg Pen	□ Inject 100mg SQ at week 0, 4, and every 8 weeks thereafter □ Inject 100mg SQ every 8 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Dupixent	□ 200mg/2ml PFS □ 200mg/2ml Pen □ 300mg/2ml Pen □ 300mg/2ml PFS	□ Inject 400mg SQ followed by 200mg every 2 weeks □ Inject 200mg SQ every 2 weeks □ Inject 600mg SQ followed by 300mg every 2 weeks □ Inject 300mg SQ every 2 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Eucrisa	□ 2% Ointment	□ Apply 1 application to the affected area(s) 2 times daily	□ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Protopic	□ 0.03% Ointment □ 0.1% Ointment	□ Apply 1 application to the affected area(s) 2 times daily	□ 30gm □ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Elidel	□ 1% Cream	□ Apply 1 application to the affected area(s) 2 times daily	□ 30gm □ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Calcipotriene	□ 0.005% Cream □ 0.005% Ointment	□ Apply 1 application to the affected area(s) 2 times daily	□ 60gm □ 120gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Qbrexza	□ 2.4% Cloth	□ Apply 1 cloth to both underarms	□ 30 cloth	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Other				

Ship to: □ Patient □ Office □ Other_____Date:_____ Need by Date_____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature:_____Date: _____