



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 _____
 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? _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cibinqo	<input type="checkbox"/> 50mg tablets <input type="checkbox"/> 100mg tablets <input type="checkbox"/> 200mg tablets	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 tabs	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Starter kit <input type="checkbox"/> 200mg/ml PFS <input type="checkbox"/> 200mg lyophilized vial	<input type="checkbox"/> 400mg SQ weeks 0, 2, 4 <input type="checkbox"/> 200mg SQ every 2 weeks <input type="checkbox"/> 400mg SQ every 4 weeks	<input type="checkbox"/> 1 kit <input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg prefilled Syringe <input type="checkbox"/> 150mg Sensoready Pen	<input type="checkbox"/> 300mg SQ at weeks 0, 1, 2, 3, & 4 followed by 300mg SQ every 4 weeks (PSO) <input type="checkbox"/> 300mg SQ every 4 weeks <input type="checkbox"/> 150mg SQ at weeks 0, 1, 2, 3, & 4 followed by 300mg SQ every 4 weeks (PSA) <input type="checkbox"/> 150mg SQ every 4 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25mg/ml <input type="checkbox"/> 50mg/ml Sureclick autoinjector <input type="checkbox"/> 50mg/ml PFS <input type="checkbox"/> 50mg Mini Cartridge	<input type="checkbox"/> 50mg SQ twice weekly for 3 months <input type="checkbox"/> 50mg SQ once weekly <input type="checkbox"/> 25mg SQ once weekly	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Humira CF	<input type="checkbox"/> Psoriasis Starter pack <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml PFS <input type="checkbox"/> 80MG/0.8ML Pen <input type="checkbox"/> Crohn/ UC/ HS Starter pack	<input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Inject 40mg SQ once weekly <input type="checkbox"/> Inject 80mg SQ on day 1 then inject 40mg on day 8 then inject 40mg every other week thereafter (Psoriasis Starter pack) <input type="checkbox"/> Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose (Crohn's/HS Starter pack)	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Ilumya	<input type="checkbox"/> 100mg/ml prefilled syringe	<input type="checkbox"/> 100mg SQ at weeks 0 & 4 followed by 100 mg every 12 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg tablets	<input type="checkbox"/> Take as directed <input type="checkbox"/> Take 30mg PO twice daily <input type="checkbox"/> Take 30mg PO once daily	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg tablets <input type="checkbox"/> 30mg tablets	<input type="checkbox"/> Take 15mg PO once daily <input type="checkbox"/> Take 30mg PO once daily	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Siliq	<input type="checkbox"/> 210mg/1.5ml PFS	<input type="checkbox"/> 210mg SQ at weeks 0, 1, & 2 followed by 210mg every 2 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml SmartJect autoinjector <input type="checkbox"/> 50mg/0.5ml PFS	<input type="checkbox"/> Inject 50mg SQ every 4 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 75mg/0.83ml prefilled syringe	<input type="checkbox"/> Inject 150mg SQ at week 0, 4, and every 12 weeks thereafter <input type="checkbox"/> Inject 150mg SQ every 12 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5ml PFS <input type="checkbox"/> 90mg/0.5ml PFS	<input type="checkbox"/> Inject 1 syringe SQ on days 0 and 28 (starter dose) <input type="checkbox"/> Inject 1 syringe SQ every 12 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80mg Auto-Injector Starter Kit (3 pens) <input type="checkbox"/> 80mg Auto-Injector (2 pens) <input type="checkbox"/> 80mg Auto-Injector (1 pen) <input type="checkbox"/> 80mg Prefilled Syringe (1 syringe)	<input type="checkbox"/> 160mg SQ on day 1, then followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, and then 80mg every 4 weeks <input type="checkbox"/> 80mg SQ every 4 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg Pen <input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Inject 100mg SQ at week 0, 4, and every 8 weeks thereafter <input type="checkbox"/> Inject 100mg SQ every 8 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Vtama	<input type="checkbox"/> 1% Cream	<input type="checkbox"/> Apply a thin layer to the affected area(s) once daily	<input type="checkbox"/> 60gm	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Adbry	<input type="checkbox"/> 150mg/ml PFS	<input type="checkbox"/> Inject 600mg SQ followed by 300mg every 2 weeks (Initial) <input type="checkbox"/> Inject 300mg SQ every 2 weeks (maintenance) <input type="checkbox"/> Inject 300mg SQ every 4 weeks for patients below 100kg who achieve clear skin after 16 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 300mg/2ml Pen <input type="checkbox"/> 300mg/2ml PFS <input type="checkbox"/> 200mg/1.14ml PFS	<input type="checkbox"/> Inject 600mg SQ followed by 300mg every 2 weeks <input type="checkbox"/> Inject 300mg SQ every 2 weeks <input type="checkbox"/> Inject 400mg SQ followed by 200mg every 2 weeks <input type="checkbox"/> Inject 200mg SQ every 2 weeks	<input type="checkbox"/> 28 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Eucrisa	<input type="checkbox"/> 2% Ointment	<input type="checkbox"/> Apply 1 application to affected area(s) 2 times daily	<input type="checkbox"/> 60gm <input type="checkbox"/> 100gm	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Opzelura	<input type="checkbox"/> 1.5% Cream	<input type="checkbox"/> Apply 1 application to affected area(s) 2 times daily	<input type="checkbox"/> 60gm	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Protopic	<input type="checkbox"/> 0.03% Ointment <input type="checkbox"/> 0.1% Ointment	<input type="checkbox"/> Apply 1 application to affected area(s) 2 times daily	<input type="checkbox"/> 30gm <input type="checkbox"/> 60gm <input type="checkbox"/> 100gm	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Elidel	<input type="checkbox"/> 1% Cream	<input type="checkbox"/> Apply 1 application to affected area(s) 2 times daily	<input type="checkbox"/> 30gm <input type="checkbox"/> 60gm <input type="checkbox"/> 100gm	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Calcipotriene	<input type="checkbox"/> 0.005% Cream <input type="checkbox"/> 0.005% Ointment	<input type="checkbox"/> Apply 1 application to affected area(s) 2 times daily	<input type="checkbox"/> 60gm <input type="checkbox"/> 120gm	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____

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 lab 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: _____

CONFIDENTIALITY STATEMENT: This communication is intended for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.