



Fax: _____
Phone: _____

Dermatology Enrollment Form

PATIENT INFORMATION

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

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code

L40.0 Psoriasis vulgaris L40.1 Generalized pustular psoriasis
 L40.2 Acrodermatitis continua L40.3 Pustulosis palmaris et plantaris
 L40.4 Guttate psoriasis L40.54 Psoriatic juvenile arthropathy
 L40.59 Other psoriatic arthropathy L73.2 Hidradenitis suppurativa
 L40.8 Other psoriasis _____
 Other Diagnosis: ICD-10 Code _____
Description _____
Date of Diagnosis _____
Has a TB test been performed? Yes No
Does the patient have an active infection? Yes No
Start Date _____ Review Date _____

Additional Information Therapy: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in
Allergies _____
Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments _____
Injection Training Required: Yes No

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200 mg/mL Prefilled Syringe Starter Kit <input type="checkbox"/> 200 mg/mL Vial Kit <input type="checkbox"/> 200 mg/mL Prefilled Syringe			
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150 mg/mL Prefilled Pen <input type="checkbox"/> 150 mg/mL Prefilled Syringe <input type="checkbox"/> 150 mg/mL (300 mg dose) Prefilled Pen <input type="checkbox"/> 150 mg/mL (300 mg dose) Prefilled Syringe			
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300 mg/2 mL Prefilled Syringe			
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50 mg/mL SureClick Autoinjector <input type="checkbox"/> 25 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> Enbrel Mini® <input type="checkbox"/> 50 mg/mL Prefilled Syringe <input type="checkbox"/> 25 mg Vial 50 mg/mL Cartridge			
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe (citrate-free) <input type="checkbox"/> 40 mg/0.8 mL Pen UC/HS Starter Pack (citrate-free) <input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe <input type="checkbox"/> 80 mg/0.8 mL Pen CD/UC/HS Starter Pack (citrate-free) <input type="checkbox"/> 80 mg/0.8 mL & 40 mg/0.4 mL Pen PS/UV Starter Pack (citrate-free) <input type="checkbox"/> 40 mg/0.8 mL Pen CD/UC/HS Starter Pack			
<input type="checkbox"/> Ilumya™	<input type="checkbox"/> 100 mg/mL Prefilled Syringe			
<input type="checkbox"/> Inflectra®	<input type="checkbox"/> 100 mg Vial <input type="checkbox"/> Starter Pack (28-day)			
<input type="checkbox"/> Otezla®	<input type="checkbox"/> 30 mg Tablet <input type="checkbox"/> Starter Pack (2-week) <input type="checkbox"/> Starter Pack (28-day)			
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg Vial			
<input type="checkbox"/> Renflexis®	<input type="checkbox"/> 100 mg Vial			
<input type="checkbox"/> Siliq®	<input type="checkbox"/> 210 mg/1.5 mL Prefilled Syringe			
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 50 mg/0.5 mL SmartJect Autoinjector			
<input type="checkbox"/> Simponi Aria®	<input type="checkbox"/> 50 mg/4 mL Vial			
<input type="checkbox"/> Skyrizi®	<input type="checkbox"/> 75 mg/0.83mL Prefilled Syringe			
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45 mg/0.5 mL Vial <input type="checkbox"/> 90 mg/mL Prefilled Syringe <input type="checkbox"/> 45 mg/0.5 mL Prefilled Syringe			
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80 mg/mL Autoinjector <input type="checkbox"/> 80 mg/mL Prefilled Syringe			
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> 100 mg/mL Prefilled Syringe			
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5 mg Tablet			
<input type="checkbox"/> Xeljanz XR®	<input type="checkbox"/> 11 mg Extended-Release Tablet			
<input type="checkbox"/> Other _____				

Ship to: Patient Office Other _____ Date _____ Needs 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 authorization 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 this 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 the 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.