

# DERMATOLOGY ENROLLMENT FORM

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## TREATMENT ARRANGEMENTS

Start Date: \_\_\_\_\_

Ship Meds:  Home  Doctor's Office

Teaching by:  Doctor's Office

Other: \_\_\_\_\_

### STATEMENT OF MEDICAL NECESSITY

L40.0 Psoriasis  L40.52 Psoriatic Arthritis  L41.4 Plaque Psoriasis  L73.2 Hidradenitis Suppurative  L20.9 Atopic dermatitis  L40.8 Moderate to Severe Plaque Psoriasis

Other: \_\_\_\_\_  Date of Diagnosis: \_\_\_\_\_ OR Years With Disease \_\_\_\_\_

### Medication assessment (Within Last 12 Months)

Atopic dermatitis  Moderate  Moderate to Severe  Severe

Psoriasis Severity:  Moderate  Moderate to Severe  Severe

Psoriasis Type:  Plaque  Other: \_\_\_\_\_

**Patient Evaluation:**

- Has Patient been diagnosed with Heart Failure?  Yes  No
- Has Patient been diagnosed with Lymphoma?  Yes  No
- Does Patient have serious/active infection?  Yes  No
- Has TB test been performed?  
If yes, results: \_\_\_\_\_ Comments: \_\_\_\_\_
- Has Hepatitis B been ruled out or treatment been initiated?  Yes  No
- Does Patient have latex allergy?  Yes  No
- Is Patient's platelet count >52,000 cells/uL?  Yes  No
- Patient Weight: \_\_\_\_\_ kg/lb
- Allergies: \_\_\_\_\_  NKDA

### Prior (FAILED) Medications:

Medication	Reason for Discontinuation
Biologics: <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> Stelara	_____
<input type="checkbox"/> Others: _____	_____
<input type="checkbox"/> Methotrexate NA	_____
<input type="checkbox"/> Topicals: _____	_____

### Patient Evaluation Cont.



NOTES: \_\_\_\_\_

\_\_\_\_\_

## PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> SKYRIZI <sup>®</sup>	<input type="checkbox"/> 75mg/0.83ml Prefilled Syringe	<input type="checkbox"/> Inject 150mg (two 75mg injections) administered by Subcutaneously at week 0, weeks 4, and every 12 weeks thereafter.	.....	.....
<input type="checkbox"/> ILUMYA <sup>®</sup>	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 100mg Subcutaneously at week 0, week 4 and every 12 weeks thereafter.	.....	.....
<input type="checkbox"/> TALTZ <sup>®</sup>	<input type="checkbox"/> 80mg/ml Autoinjector <input type="checkbox"/> 80mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 160mg (two 80mg injections) Subcutaneously at week 0, followed by 80mg at Weeks 2, 4, 6, 8, 10, and 12, then 80mg every 4 Weeks.	.....	.....
<input type="checkbox"/> SILIQ <sup>®</sup>	<input type="checkbox"/> 210mg/1.5ml Prefilled Syringe	<input type="checkbox"/> Inject 210mg Subcutaneously at week 0, 1 and 2 followed by 210mg every 2 weeks thereafter.	.....	.....
<input type="checkbox"/> TREMFYA <sup>®</sup>	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 100mg Subcutaneously at week 0, Week 4 and every 8 weeks thereafter.	.....	.....
<input type="checkbox"/> DUPIXENT <sup>®</sup>	<input type="checkbox"/> 300mg/2ml Prefilled Syringe	<input type="checkbox"/> Inject 600mg (2 Prefilled Syringes) Subcutaneously in different sites on day 1. <input type="checkbox"/> Inject 300mg (1 Prefilled Syringe) Subcutaneously every other week starting day 15 after initial dose.	.....	.....
<input type="checkbox"/> ENBREL <sup>®</sup>	<input type="checkbox"/> SureClick <sup>®</sup> Pen <input type="checkbox"/> Mini <sup>™</sup> with Auto Touch <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> Vials 25mg	<input type="checkbox"/> Initial: Inject 50mg SQ twice weekly (72-96 hours apart) for 3 months. <input type="checkbox"/> Maintenance: Inject 50mg SQ weekly. <input type="checkbox"/> Others:.....	.....	.....
<input type="checkbox"/> HUMIRA <sup>®</sup>	<input type="checkbox"/> Psoriasis STARTER Pack <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> Psoriasis STARTER Dose: Inject 80mg Subq on day 1, 40mg on day 8 and 40mg day 22 then maintenance. <input type="checkbox"/> Psoriasis Maintenance Dose: Inject 40mg Subq every other week.	.....	.....
<input type="checkbox"/> HUMIRA CF <sup>®</sup> (Citrate-free)	<input type="checkbox"/> Hidradenitis Suppurativa (HS) STARTER Pack <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> HS Initial dose: Inject 160mg Subq on day 1, then 80mg on day 15 and then maintenance. <input type="checkbox"/> HS Maint dose: Inject 40mg Subq every week.	.....	.....
<input type="checkbox"/> SIMPONI <sup>®</sup>	<input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg Prefilled Syringe	<input type="checkbox"/> Psoriatic Arthritis Dose: Inject 50mg (0.5ml) Subcutaneously Once a month.	.....	.....
<input type="checkbox"/> STELARA <sup>®</sup>	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 90mg/ml Prefilled Syringe	<input type="checkbox"/> For patients weighing < 100kg (220lbs): Inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks. <input type="checkbox"/> For patients weighing > 100kg (220lbs): Inject 90mg SC initially and 4 weeks later, followed by 90mg every 12 weeks.	.....	.....
<input type="checkbox"/> CIMZIA <sup>®</sup>	<input type="checkbox"/> 200mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 400mg (given as 2 injections 200mg) Subq every other week. <input type="checkbox"/> Loading dose: Inject 400mg (given as 2 injections 200mg) Subq at week 0,2 and 4. <input type="checkbox"/> Maintenance dose: Inject 200mg Subq every other week.	.....	.....
<input type="checkbox"/> OTEZLA <sup>®</sup>	<input type="checkbox"/> 10mg <input type="checkbox"/> 30mg <input type="checkbox"/> 28days starter pack	<input type="checkbox"/> Take 10mg PO qd on day 1, and increasing by 10mg daily until taking 30mg BID thereafter. <input type="checkbox"/> Take 30mg (1 tablet) by mouth twice daily.	.....	.....
<input type="checkbox"/> COSENTYX <sup>®</sup>	<input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> Psoriasis loading Dose: Inject 300mg (two injections) SC at weeks 0, 1, 2, 3 and 4. <input type="checkbox"/> Psoriasis Maintenance Dose: Inject 300mg (two injections) SC every 4 weeks.	.....	.....

Physician Signature: x \_\_\_\_\_  DAW (Dispense as Written) Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Physician Address: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

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