Fax Referral To:
814-283-2211

Phone 855-265-8008

VALUE SPECIALTY PHARMACY

1333 Plank Road, Suite 200, Duncansville, PA 16635

Dermatology Enrollment Form

Ship to: ☐ Patient ☐ Office ☐ Other

Date: _____ **Needs by date:** _____

Is patient new to this therapy? ☐ YES ☐ NO

Documents necessary for facilitation of referral: ☐ Enrollment form ☐ Front/Back copies of all insurance/prescription cards ☐ Labwork and medication profile

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
NPI #: _____
DEA #: _____ State License #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Diagnosis:

Please include diagnosis name and ICD-10:

_____

_____

Additional Clinical Information:

Weight: _____ kg/lbs • Height: _____ in/cm

Allergies: _____

Failed Therapies/Dates: _____

INJECTION TRAINING ☐ **MD to coordinate** ☐ **Value Specialty Pharmacy to coordinate**

☐ **Cimzia (PsA)**	☐ **200mg/ml prefilled syringe** ☐ **200mg/ml vial**	☐ **Induction: Inject 400mg subcutaneously on days 0, 14, 28** ☐ **Maintenance: Inject 400mg subcutaneously every 28 days** ☐ **Maintenance: Inject 200mg subcutaneously every 14 days**
☐ **Cosentyx**	☐ **150mg pen** ☐ **150mg prefilled syringe**	☐ **Induction: 300mg (2 x 150mg) subcutaneously at weeks 0,1,2,3,4** ☐ **Maintenance: Inject 300mg (2 x 150mg) subcutaneously every 28 days**
☐ **Enbrel**	☐ **50mg/ml prefilled syringe** ☐ **50mg/ml Sureclick autoinjector**	☐ **Induction: Inject 50mg subcutaneously twice weekly x 3 months** ☐ **Maintenance: Inject 50mg subcutaneously every 7 days**
☐ **Humira**	☐ **40mg/0.8ml pen** ☐ **40mg/0.8ml prefilled syringe**	☐ **Induction: Inject 80mg subcutaneously on Day 1, then 40mg subcutaneously on Day 8 then 40mg subcutaneously on Day 22** ☐ **Maintenance: Inject 40mg subcutaneously every 14 days**
☐ **Otezla**	☐ **10mg/20mg/30mg starter pack** ☐ **30mg**	☐ **Titration Schedule: Day 1-10mg in AM, Day 2- 10mg twice daily, Day 3 – 10mg in AM, 20mg in PM, Day 4 – 20mg twice daily, Day 5 – 20mg in AM, 30mg in PM, then 30mg twice daily** ☐ **30mg twice daily**
☐ **Simponi (PsA)**	☐ **50mg/0.5ml syringe** ☐ **50mg/0.5ml autoinjector**	☐ **Inject 50mg subcutaneously every 28 days**
☐ **Stelara**	☐ **45mg/0.5ml prefilled syringe (<100kg)** ☐ **90mg/ml prefilled syringe (>100kg)**	☐ **Induction: Inject ____ mg subcutaneously at days 0 and 28** ☐ **Maintenance: Inject _____mg subcutaneously every 84 days (12wks)**

QUANTITY AND REFILLS: **Dispense # _____ with _____ refills.**

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

_____
Physician Signature

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right

☐