Dermatology Enrollment Form A-N

VALUE SPECIALTY PHARMACY

Date:_____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs☐ kg☐

SSN #: XXX-XX-_____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Primary Language: _____

Authorized Contact: _____ Contact's Phone: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____

ID: _____ Group#: _____ ID: _____ Group#: _____

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Diagnosis: _____ **ICD 10 code:** _____ **Date of Diagnosis (or years with disease):** _____

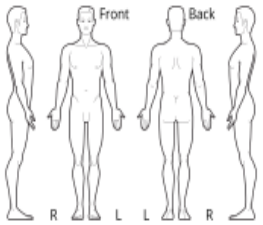
Severity: ☐ Moderate ☐ Moderate to Severe ☐ Severe **Dose patient have a latex allergy?** ☐ Yes ☐ No _____ % BSA affected by Psoriasis

Has patient received PPD (tuberculosis) skin test? ☐ Yes ☐ No Date: _____ Results: ☐ Positive ☐ Negative

Has patient been tested for Hepatitis B? ☐ Yes ☐ No **If positive, has treatment been initiated?** ☐ Yes ☐ No

Has patient previously been treated for this condition? ☐ Yes ☐ No Injection Training Needed? ☐ Yes ☐ No

If yes, medication/therapy failed (length of therapy): _____



Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ 200mg/ml PFS ☐ 200mg/ml vial	☐ Induction: Inject 400mg SQ on days 0, 14, 28	#6	0 refills
		☐ Maintenance: Inject 400mg SQ every 28 days ☐ Maintenance: Inject 200mg SQ every 14 days		
☐ Cosentyx®	☐ 150mg pen ☐ 150mg PFS	☐ Induction: 300mg (two injections) SQ at weeks 0, 1, 2, 3, 4	#10	0 refills
		☐ Maintenance: Inject 300mg (two injections) SQ every 28 days	#2	
☐ Dupixent®	300mg/2ml PFS	☐ Induction: Inject 600mg (two injections) SQ on day 0	#2	0 refills
		☐ Maintenance: Inject 300mg SQ every other week	#2	
☐ Enbrel®	☐ 50mg/ml PFS ☐ 50mg/ml SureClick™ Autoinjector ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml vial	☐ Induction: Inject 50mg SQ twice weekly for 3 months	#8	2 refills
		☐ Maintenance: Inject 50mg SQ every 7 days ☐ Other: _____		
☐ Enbrel® Mini™ *AutoTouch™ device available only through RxCrossroads*	50mg/ml cartridge	☐ Induction: Inject 50mg SQ twice weekly for 3 months	#8	2 refills
		☐ Inject 50mg SQ every 7 days	#4	
☐ Humira®	☐ Psoriasis Starter Package	☐ Induction: Inject 80mg (two injections) SQ on day 1, then one 40mg pen on day 8, then one 40mg pen every other week	1 package	0 refills
	☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml pen	☐ Maintenance: Inject 40mg SQ every other week	#2	
☐ Humira® *Citrate Free*	☐ Psoriasis Starter Package (pens only) 1-80mg/0.8ml and 2-40mg/0.4ml	☐ Induction: Inject 80mg (1 injection) SQ on day 1; Inject 40mg (1 injection) SQ on day 8 and day 22	#3	0 refills
	☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml pen	☐ Maintenance: Inject 40mg SQ every other week	#2	
☐ Ilumya™	100mg/1ml PFS	☐ Induction: Inject 100mg SQ on weeks 0 and 4	#2	0 refills
		☐ Maintenance: Inject 100mg SQ every 12 weeks	#1	

Is patient new to this therapy: ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other | **Desired Start Date:** _____

Prescriber Data

Prescribers Name: _____ DEA#: _____ NPI: _____

Practice Name: _____ Contact: _____

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____ Key Contact#: _____

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 process.

Physician Signature: _____ Date: _____

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