VALUE SPECIALTY PHARMACY — Dermatology Enrollment Form A-I

Patient Data

Patient Name: ______________________ Birthdate: __________
SSN #: XXX-XX-______________
Address: ______________________
Home Phone: ______________ Cell Phone: ______________
Alternate Caregiver Name/Phone: ______________________
Sex: ❑ Male ❑ Female Height: _____ Weight: ________ lbs kg
Known Allergies: ______________________
City: ______________ State: __________ Zip: __________
Primary Language: ______________________
Patient Email: ______________________

Ins. Data

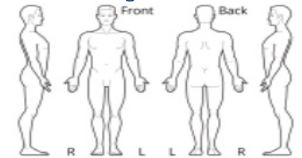
Primary Insurance: ______________________
Policy: ______________________ Group#: __________
Secondary Insurance: ______________________
Policy: ______________________ Group#: __________

❑ ***Patient has commercial insurance and authorizes pharmacy to apply for manufacturer copay card. Email must be provided above.***

Clinical Information

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

Diagnosis: ______________________ ICD 10: ______________ Date of Diagnosis: __________
Severity: ❑Moderate ❑Moderate to Severe ❑Severe Does patient have a latex allergy? ❑Yes ❑No __________% BSA affected
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
❑ Cibinqo™	❑ 50mg tablet ❑ 100mg tablet ❑ 200mg tablet	Take 1 tablet orally once daily	#30	
❑ Cimzia®	❑ 200mg/ml PFS ❑ 200mg/ml vial	❑ Maintenance: Inject 400mg SQ every 4 weeks	#2	
		Optional induction dosing for patients 90kg or less ❑ Induction: Inject 400mg SQ at weeks 0, 2, and 4	#6	0 refills
		❑ Maintenance: Inject 200mg SQ every 14 days Patient weight __________kg	#2	
❑ Cosentyx®	❑ 150mg/ml PFS ❑ 150mg/ml pen	❑ Induction: Inject 300mg (two injections) SQ at weeks 0, 1, 2, 3, and 4	#10	0 refills
		❑ Maintenance: Inject 300mg (two injections) SQ every 4 weeks	#2	
❑ Dupixent®	❑ 300mg/2ml PFS ❑ 300mg/2ml pen	❑ Induction: Inject 600mg (two injections) SQ on day 0	#2	0 refills
		❑ Maintenance: Inject 300mg SQ every 2 weeks	#2	
❑ Enbrel®	❑ 50mg/ml PFS ❑ 50mg/ml SureClick™ Autoinjector ❑ 50mg/ml mini cartridge *AutoTouch device available only through RxCrossroads*	❑ Induction: Inject 50mg SQ twice weekly for 3 months	#8	2 refills
		❑ Maintenance: Inject 50mg SQ once weekly	#4	
❑ Humira® *Citrate Free*	*Patients with Plaque Psoriasis* ❑ Psoriasis Starter Package (pens only) *1-80mg/0.8ml and 2-40mg/0.4ml pens*	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 14 days	#2	
	Patients with Hidradenitis Suppurativa ❑ Hidradenitis Suppurativa Starter Package (pens only) *3-80mg/0.8ml pens*	Induction: Inject 160mg (two injections) SQ on day 1; Inject 80mg (1 injection) SQ on day 15 then start maintenance dose at day 29	#3	0 refills
	❑ 40mg/0.4ml PFS ❑ 40mg/0.4ml pen	Maintenance: Inject 40mg SQ every 7 days	#4	
	❑ 80mg/0.8ml pen	Maintenance: Inject 80mg SQ every 14 days	#2	
❑ Ilumya™	100mg/ml 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 | **Needs by Date:** __________

Prescriber Data

Prescriber Name: ______________________
Practice Name: ______________________
Address: ______________________
City: ______________ State: __________ Zip: __________
DEA#: ______________ NPI: ______________
Contact: ______________________
Phone: ______________ Fax: ______________
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.

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**