Dermatology Enrollment Form O-Z

VALUE SPECIALTY PHARMACY

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#: _____

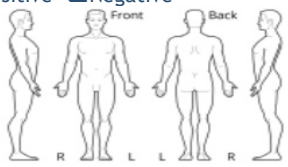
Secondary Insurance: _____
Policy: _____ Group#: _____

❑ ***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
❑ Orencia®	❑ 125mg/ml PFS ❑ 125mg/ml ClickJect™ autoinjector	Inject 125mg SQ every 7 days	#4	
❑ Otezla®	❑ Titration Starter Pack	Induction: Use as directed per titration pack instructions	#1 pack	0 refills
	❑ 30mg tablet	Maintenance: Take 1 tablet orally twice daily	#60	
❑ Rinvoq®	❑ 15mg tablet ❑ 30mg tablet	❑ Take 1 tablet orally once daily	#30	
❑ Siliq®	210mg/ml PFS	❑ Induction: Inject 210mg SQ on weeks 0, 1, and 2	#3	0 refills
		❑ Maintenance: Inject 210mg SQ every 2 weeks	#2	
❑ Simponi®	❑ 50mg/0.5ml PFS ❑ 50mg/0.5ml SmartJect autoinjector	Inject 50mg SQ once every 28 days	#1	
❑ Skyrizi®	❑ 75mg/0.83ml PFS ❑ 150mg/ml pen ❑ 150mg/ml PFS	❑ Induction: Inject 150mg SQ on weeks 0 and 4	Quantity Sufficient x2 doses	0 refills
		❑ Maintenance: Inject 150mg SQ every 12 weeks	Quantity Sufficient x1 dose	
❑ Sotyktu™	6mg tablet	Take 1 tablet orally once daily with or without food	#30	
❑ Stelara®	❑ 45mg/0.5ml PFS ❑ 90mg/1ml PFS	*Patient weight 100kg or less* ❑ Induction: Inject 45mg SQ at weeks 0 and 4	#2	0 refills
		❑ Maintenance: Inject 45mg SQ every 12 weeks Patient weight _____kg	#1	
		Patient weight greater than 100kg ❑ Induction: Inject 90mg SQ at weeks 0 and 4	#2	0 refills
		❑ Maintenance: Inject 90mg SQ every 12 weeks Patient weight _____kg	#1	
❑ Taltz®	❑ 80mg/ml PFS ❑ 80mg/ml autoinjector	❑ Induction: Inject 160mg (two injections) SQ at week 0, then inject 80mg (1 injection) at weeks 2, 4, 6, 8, 10, and 12	#8	0 refills
		❑ Maintenance: Inject 80mg SQ every 4 weeks	#1	
❑ Tremfya®	❑ 100mg/ml PFS ❑ 100mg/ml One-Press	❑ Induction: Inject 100mg SQ on weeks 0 and 4	#2	0 refills
		❑ Maintenance: Inject 100mg SQ every 8 weeks	#1	
❑ Xeljanz®	5mg tablet	Take 1 tablet orally twice daily	#60	
❑ Xeljanz XR®	11mg tablet	Take 1 tablet orally once daily	#30	

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.