



## Dermatology Enrollment Form

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PATIENT INFORMATION				
Name:		Date of Birth:		O Male    O Female
Address:		City:	State:	Zip:
Phone:		Alt Phone:		Email:
SS #:		Primary Language:		Emergency Contact:
PRESCRIBER INFORMATION				
Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:		City:	State:	Zip:
Phone:		Fax:		Office Contact:
MEDICAL INFORMATION				
** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **				
ICD-10 Code & Description: _____				
<b>Patient Evaluation:</b> Height: _____ in/cm    Weight: _____ kg/lbs Allergies: _____ Eosinophils: _____ Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No   Date: _____    Hep B rules out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> No   Date: _____ <b>Needs by Date:</b> _____    Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other: _____				
MEDICATION				
<input type="checkbox"/> Adalimumab-aacf (Idadacio)	<input type="checkbox"/> Enbrel	<input type="checkbox"/> Simlandi	<input type="checkbox"/> Ustekinumab	
<input type="checkbox"/> Adalimumab-aaty (Yuflyma)	<input type="checkbox"/> Hadlima	<input type="checkbox"/> Simponi	<input type="checkbox"/> Xeljanz	
<input type="checkbox"/> Adalimumab-adaz (Hyrimoz)	<input type="checkbox"/> Humira	<input type="checkbox"/> Skyrizi	<input type="checkbox"/> Yesintek	
<input type="checkbox"/> Adalimumab-fkjp (Hulio)	<input type="checkbox"/> Ilumya	<input type="checkbox"/> Sotyktu	<input type="checkbox"/> Yuflyma	
<input type="checkbox"/> Amjevita	<input type="checkbox"/> Olumiant	<input type="checkbox"/> Stelara	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Bimzelx	<input type="checkbox"/> Orencia	<input type="checkbox"/> Steqeyma		
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Otezia	<input type="checkbox"/> Taltz		
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> Rinvoq	<input type="checkbox"/> Tremfya		
<input type="checkbox"/> Dupixent	<input type="checkbox"/> Selarsdi			
PRESCRIPTION INFORMATION				
Dosage Form	Dose	Directions	Qty/Day Supply	Refills
	Initial Dose:		Qty _____ Day supply: _____	
	Maintenance Dose:		Qty _____ Day supply: _____	
	Other:		Qty _____ Day supply: _____	
INJECTION TRAINING				
<input type="checkbox"/> Patient has received pen & injection training <input type="checkbox"/> Physician's office to provide injection training <input type="checkbox"/> Pharmacy to coordinate injection training				

**PRESCRIBING PRACTITIONER SIGNATURE**

**Prescribing Practitioner:** The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing this form and utilizing our services, you are also authorizing Medford Chemists Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

☐ **DAW Brand Medically Necessary**

☐ **May substitute/ Substitution Permissible**

Prescribing Practitioner

Date

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**Dermatology Enrollment Form (2/2)**

