# Dermatology Enrollment Form
## Medford Chemists

2608 Route 112, Medford, NY 11763 | Email: info@medfordchemists.com | Phone: 1-855-MEDCHEM | Fax: 631-475-4288

### PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Name: | Date of Birth: | | | O Male O Female |
| Address: | City: | | State: | Zip: |
| Phone: | Alt Phone: | | | Primary Language: |
| Emergency Contact, phone: | Patient Email: | | | SS#: |

### PRESCRIBER INFORMATION

| | | | | |
|---|---|---|---|---|
| Prescribing Practitioner: | | | | NPI#: |
| Supervising Physician: | | | | NPI#: |
| Address: | City: | State: | Zip: | Tax ID: |
| Phone: | Office Contact: | | | Fax: |

### MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION/MEDICAL COVERAGE CARD, FRONT & BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

ICD-10 Code & Description: _____

**Patient Evaluation:** Height:_____ in/cm Weight: _____ kg/lbs

Allergies: _____

Eosinophils: _____

Active TB is ruled out: ☐ Yes ☐ No Date: _____ Hep B ruled out/treated: ☐ Yes ☐ No Date:_____

**Needs by Date**: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

### MEDICATION

| | | | | |
|---|---|---|---|---|
| ☐ Humira® (adalimumab) | ☐ Hulio® (Humira® biosimilar) | ☐ Enbrel® | ☐ Taltz® | ☐ Bimzelx® |
| ☐ Idacio® (Humira® biosimilar) | ☐ Simlandi® (Humira® biosimilar) | ☐ Ilumya® | ☐ Tremfya® | ☐ Cimzia® |
| ☐ Yuflyma® (Humira® biosimilar) | ☐ Stelara® (ustekinumab) | ☐ Olumiant® | ☐ Simponi® | ☐ Cosentyx® |
| ☐ Hyrimoz® (Humira® biosimilar) | ☐ Selarsdi® (Stelara® biosimilar) | ☐ Orencia® | ☐ Skyrizi® | ☐ Dupixent® |
| ☐ Amjevita® (Humira® biosimilar) | ☐ Yesintek® (Stelara® biosimilar) | ☐ Otezla® | ☐ Sotyktu® | ☐ Other: _____ |
| ☐ Hadlima® (Humira® biosimilar) | ☐ Steqeyma® (Stelara® biosimilar) | ☐ Rinvoq® | ☐ Xeljanz® | |

### PRESCRIPTION INFORMATION

| Dosage Form | Dose | Directions | Qty/Day Supply | Refills |
|---|---|---|---|---|
| | Initial Dose: | | Qty_____<br>Day supply: _____ | |
| | Maintenance Dose: | | Qty_____<br>Day supply: _____ | |
| | Other: | | Qty_____<br>Day supply: _____ | |

### INJECTION TRAINING

☐ Patient has received pen & injection training ☐ Physician's office to provide injection training ☐ 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

### CONFIDENTIALITY NOTICE