Elite Specialty Pharmacy
Your Choice Above The Rest

Dermatology Enrollment Form

Fax Referrals To: (877) 577-6447

Nzone-Elite Specialty Pharmacy
10210 101st Ave
Ozone Park, NY 11416
Toll Free: (877) 577-1447

PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ M ☐ F ☐ SS#: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION:

Name: _____
Group/Institution: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY:

(Please Attach All Medical Documentation)

Date of Diagnosis: _____
❑ L40.0 Psoriasis
❑ L40.52 Psoriatic Arthritis
❑ L73.2 Hidradenitis Suppurativa
❑ Other: _____
TB Test: ❑ Positive ❑ Negative Date: _____
Assessment: ❑ Moderate ❑ Mod to Severe ❑ Severe
_____% BSA affected
❑ Hands ❑ Scalp ❑ Feet ❑ Groin ❑ Nails

Serious or active infection present? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
History of malignancy? ❑ Yes ❑ No
History of MS or other demyelinating disease? ❑ Yes ❑ No
New onset CHF or worsening CHF? ❑ Yes ❑ No
Contraindications for oral agent(s) or phototherapy? ❑ No ❑ Yes _____

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Topicals	
❑ Methotrexate	
❑ Oral Meds	
❑ Biologics	
❑ PUVA ❑ UVB	
❑ Others	

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
Cosentyx®	☐ 150 mg/mL Sensoready pen ☐ 150 mg/mL pre-filled syringe	☐ **Initial**: 300 mg weekly for 5 weeks ☐ **Maintenance**: 300 mg every four weeks		
Dupixent®	☐ 300 mg/2mL pre-filled syringe	☐ **Initial**: Inject 600 mg SC once ☐ **Maintenance**: Inject 300 mg SC every other a week		
Enbrel®	☐ 50 mg/mL Autoinjector ☐ 50 mg/mL pre-filled syringe	☐ **Initial**: Inject 50 mg SC TWICE a week (72-96 hours apart) X 3 months ☐ **Maintenance:**Inject 50 mg SC ONCE a week		
Enstilar®	☐ 60 gm topical foam ☐ 120 gm topical foam	☐ Apply to affected areas once daily for up to 4 weeks		
Humira®	☐ 40 mg/0.8mL Pen ☐ 40 mg/0.8mL pre-filled syringe	☐ **Initial**: 80 mg day 1, then 40 mg one week later, then 40 mg every other week ☐ **Maintenance**: 40 mg every two weeks ☐ Inject 40 mg SC ONCE a week		
Otezla®	☐ **Starter (Titration) Pak** – take as directed X 28 days ☐ **Maintenance Dose** – 30 mg twice daily by mouth ☐ Other:			
Otrexup™	☐ 10 mg/0.4 mL ☐ 15 mg/0.4 mL ☐ 20 mg/0.4 mL ☐ 25 mg/0.4 mL Directions:			
Stelara®	☐ 45 mg/0.5 mL pre-filled syringe ☐ 90 mg/mL pre-filled syringe	☐ **Initial**: Inject the contents of 1 pre-filled syringe SC on day 1 ☐ **Maintenance**: Inject the contents of 1 pre-filled syringe SC starting day 29 & every 12 weeks thereafter		
Taltz®	☐ 80 mg/mL single dose pre-filled autoinjector ☐ 80 mg/mL single dose pre-filled syringe	☐ **Initial**: Inject 160 mg (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks. ☐ **Maintenance**: Inject 80 mg every 4 weeks.		
Tremfya®	☐ 100 mg/mL pre-filled syringe	☐ **Initial**: Inject 100 mg SC at week 0 and week 4 ☐ **Maintenance**: Inject 100 mg SC every 8 weeks thereafter		

INJECTION TRAINING: ☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRODUCT DELIVERY: ☐ Patient's home ☐ Physician's Office ☐ Pharmacy to coordinate

INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIBER SIGNATURE:

Your signature authorizes Nzone Pharmacy, LLC and its representatives to act on your behalf to obtain prior authorization for the prescribed medications. We will also purse available copay and financial assistance on behalf of your patients.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.