Bell Pharmacy

Dermatology Enrollment Form H-Z

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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:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

Drug	Dose	Direction & Quantities	Refills
O Humira O Humira CF	O Psoriasis Starter Kit O Pen O Pre-filled Syringe	O INITIAL: Inject 80 mg SQ on day 1,40 mg on day 8, then 40 mg every other week (1Kit) O MAINTENANCE: Inject 40 mg SQ every other week (Qty: 2)	
	O HS Starter Kit O Pen O Pre-filled Syringe	O INITIAL: Inject 160 mg SQ on day 1, then 80 mg on day 15 (1 Kit) O MAINTENANCE: Inject 40 mg SQ every week (Qty: 4)	
Ilumya ™	O 100 mg Pre-filled syringe	O INITIAL: Inject 100 mg SC at week 0 and week 4 (Qty: 2) O MAINTENANCE: Inject 100 mg SC every 12 weeks (Qty: 1)	
Otezla®	O 28 Day Starter Pack	O Take as directed per package instructions. (Qty: 55)	
	O Maintenance	O Take 30 mg PO twice daily (Qty: 60) O Take 30 mg PO once daily (Qty: 30). Renal Dosing Continuation of Therapy: O Yes O No	
Siliq ™	O Pre-filled Syringe	O INITIAL: Inject 210 mg SC on weeks 0 and 1 (Qty: 2) O MAINTENANCE: Inject 210mg SC every 2 weeks starting at week 2 (Qty: 2) O REMS	
Skyrizi™	O Pre-filled Syringe O Pen injector	O INITIAL: Inject 150 mg SC at week 0 and week 4 O MAINTENANCE: Inject 150 mg SC every 12 weeks thereafter	
Stelara®	O 45 mg <100 kg O 90 mg >100kg O Vials 45 mg	O INITIAL: Inject SC on day 0 and day 28 (Qty: 2) O MAINTENANCE: Inject SC every 12 weeks (Qty: 1)	
Taltz®	O 80 mg/ml autoinjector O 80 mg/ml Pre-filled syringe	O INITIAL: inject 160mg SC at week 0, then begin induction dose 2 weeks later. (Qty: 3 O INDUCTION DOSE: inject 80mg SC every two weeks (weeks 4 - 10). (Qty: 2 pens/syringes) O FINAL INDUCTION DOSE: inject 80mg SC at week 12. (Qty: 1 pen/syringe) O MAINTENANCE DOSE: inject 80 mg SC every 4 weeks (thereafter) (Qty: 1 pen/syringe)	
Tremfya ™	O Pre-filled Syringe O One - Press Injector	O INITIAL: Inject 100 mg SC on week 0 and week 4 (Qty: 1) (Refill: 1) O MAINTENANCE: Inject 100 mg SC every 8 weeks (Qty: 1)	

MEDICAL INFORMATION

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

PREVIOUS THERAPIES:			PHOTOTHERAPY
	O Cyclosporine	O Elidel	O UVA /UVB
	O Methotrexate	O Eucrisa	
	O Soriatane	O Stelara	
	O Clobetasol	O Humira	O Other: ______________________
	O Hydrocortisone	O Enbrel	

Tried & Failed (Duration):

Contradiction:

O L40.0 Psoriasis Vulgaris (Plaque Psoriasis) O L40.9: Psoriasis, unspecified. O L32.2 HS Date of Diagnosis: ____/____/______

Active TB is ruled out: O Yes O No Date: ____/____/______ Hep B ruled out/treated: O Yes O No Date: ____/____/______

Allergies: Patient Height:________________ in/cm Weight: ________________ kg/lbs

Additional Clinical Information:

AMERICAN ACADEMY OF DERMATOLOGY CONSENSUS STATEMENT ON PSORIASIS THERAPIES

O Psoriasis is covering greater than 10% of body surface area O Psoriasis is on palms, soles, head and neck, or genitalia

O Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints

O Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships.

INJECTION TRAINING

O Patient has received pen and injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: ___

designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

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Faxed Prescriptions will only be accepted from a prescribing practitioner.