# Bell Pharmacy

Dermatology Enrollment Form A-G

1907 State Route 27, Edison, NJ 08817 | www.bellpharmacy.net | Email: contact@bellpharmacy.net | Phone: 732-985-1211 | Fax: 732-985-3609

## 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 Botox | O 100 unit vial<br>O 200 unit vial | O Frequency: _____ (minimum is 12 weeks, unless otherwise specified)<br>O Location for injection (specify site(s)): _____<br>O Number of units per site: _____ | |
| O Cimzia | O Pre-filled Syringe<br>O Vials | O Inject 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week.<br>For some patients (with body weight <90kg), a dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4, followed by 200 mg every other week. | |
| O Cosentyx | O Sensoready Pen<br>O Pre-filled Syringe | O INITIAL: Inject 300 mg SC on week 0, 1, 2, 3, and 4 (Qty: 10)<br>O MAINTENANCE: Inject 300 mg SC every 4 weeks (Qty: 2) | |
| O Dupixent | O Pre-filled Syringe<br>O Pen | O INITIAL: Inject 600 mg (two 300 mg injections in different sites) SC on day 1 (Qty: 2)<br>O MAINTENANCE: Inject 300 mg SC every other week starting at day 15 (Qty: 2) | |
| O Enbrel | O SureClick® Pen<br>O Mini™ with AutoTouch™<br>O Pre-filled Syringe<br>O 25 mg O 50 mg<br>O Vials 25 mg | O INITIAL: Inject 50 mg SC twice weekly (72-96 hours apart) for 3 months (Qty: 8 w/ 2 refills)<br>O MAINTENANCE: Inject 50 mg SC weekly (Qty: 4) | |

## MEDICAL INFORMATION

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

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

Tried & Failed (Duration):

Contradiction:

O L20.9 Atopic Dermatitis (Moderate to Severe) O L40.0 Psoriasis Vulgaris (Plaque Psoriasis)

O Other: _____ Date of Diagnosis: ____/____/_____

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

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 Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

## PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

_____

Prescribing Practitioner: Date

## CONFIDENTIALITY NOTICE



Faxed Prescriptions will only be accepted from a prescribing practitioner.