

# DERMATOLOGY ENROLLMENT FORM

PLEASE FAX TO: 207-899-0968

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## PATIENT INFORMATION

Patient Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		Phone:	Alt Phone:
Height:	Weight:	Allergies :	

## DIAGNOSIS

<input type="checkbox"/> Psoriasis (L40.0) <input type="checkbox"/> Atopic Dermatitis unspecified (L20.9) <input type="checkbox"/> Hidradenitis suppurativa (L73.2) <input type="checkbox"/> Other:	_____ % BSA affected by psoriasis Affected areas include palms, soles, head, neck, or genitalia: <input type="checkbox"/> Yes <input type="checkbox"/> No Additional justification for drug:
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## CLINICAL INFORMATION

<b>Treatment history:</b> <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Drug change <b>Failed therapies:</b> <input type="checkbox"/> Enbrel <input type="checkbox"/> Humira <input type="checkbox"/> Stelara <input type="checkbox"/> Remicade <input type="checkbox"/> MTX <input type="checkbox"/> PUVA <input type="checkbox"/> UVB <input type="checkbox"/> Topicals	<b>Date of TB test:</b> _____ <b>Results:</b> <input type="checkbox"/> negative <input type="checkbox"/> pending <b>Current therapy:</b> _____ <b>Stop before starting new therapy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Withhold for how long before starting:</b> _____
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DRUG	DIRECTIONS	QTY	REF
<input type="checkbox"/> Cimzia <input type="checkbox"/> 200 mg vial <input type="checkbox"/> 200 mg PFS	<input type="checkbox"/> Inject 400 mg (two 200 mg injections) SQ every other week		
<input type="checkbox"/> Cosentyx <input type="checkbox"/> 150 mg PFS <input type="checkbox"/> 150 mg Sensoready pen	<input type="checkbox"/> <b>Loading dose:</b> Inject 300mg (two 150 mg injections) SQ at weeks 0, 1, 2, 3, & 4, then maint. <input type="checkbox"/> <b>Maintenance dose:</b> Inject 300 mg (two 150 mg injections) SQ every 4 weeks	QS	0
<input type="checkbox"/> Dupixent 300 mg PFS	<input type="checkbox"/> <b>Loading dose:</b> Inject 600 mg (two 300 mg injections) SQ once, then maintenance <input type="checkbox"/> <b>Maintenance dose:</b> Inject 300 mg SQ every other week	2	0
<input type="checkbox"/> Enbrel <input type="checkbox"/> 25 mg vial <input type="checkbox"/> 25 mg PFS <input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 50 mg Sureclick pen <input type="checkbox"/> 50 mg Mini cartridge	<input type="checkbox"/> <b>Plaque psoriasis loading dose:</b> Inject 50 mg SQ twice a week (72-96h apart) for 3 months, then begin maintenance dose <input type="checkbox"/> <b>Maintenance dose:</b> Inject 50 mg SQ once weekly <i>*Office must supply autoinjector device for Enbrel Mini Device</i>	24	0
<input type="checkbox"/> HUMIRA <input type="checkbox"/> HUMIRA Citrate Free (lower volume) <input type="checkbox"/> Humira Psoriasis loading dose Pen Kit <input type="checkbox"/> Humira HS loading dose Pen Kit <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg PFS	<b>Psoriasis</b> <input type="checkbox"/> <b>Loading dose:</b> Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week <input type="checkbox"/> <b>Maintenance dose:</b> Inject 40 mg SQ every other week <b>Hidradenitis suppurativa</b> <input type="checkbox"/> <b>Loading dose:</b> Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg starting on day 29 <input type="checkbox"/> <b>Maintenance dose:</b> Inject 40 mg SQ every week		0
<input type="checkbox"/> Ilumya 100 mg PFS	<input type="checkbox"/> <b>Loading dose:</b> Inject 100 mg SQ at weeks 0 and 4, then begin maintenance <input type="checkbox"/> <b>Maintenance dose:</b> Inject 100 mg SQ every 12 weeks	2	0
<input type="checkbox"/> Otezla <input type="checkbox"/> 10/20/30 titration pack <input type="checkbox"/> 30 mg tablets	<input type="checkbox"/> <b>Loading dose:</b> Take as directed on titration pack <b>or</b> Given by office on ____/____/____ <input type="checkbox"/> <b>Maintenance dose:</b> Take 1 tablet PO BID	55	0
<input type="checkbox"/> Siliq <input type="checkbox"/> 210 mg PFS	<input type="checkbox"/> <b>Loading dose:</b> Inject 210 mg SQ on weeks 0, 1, and 2, then once every 2 weeks <input type="checkbox"/> <b>Maintenance dose:</b> Inject 210 mg SQ every 2 weeks	2	0
<input type="checkbox"/> Skyrizi <input type="checkbox"/> 75 mg PFS	<input type="checkbox"/> <b>Loading dose:</b> Inject 150 mg (two 75 mg injections) SQ at weeks 0 and 4, then maint. <input type="checkbox"/> <b>Maintenance dose:</b> Inject 150 mg (two 75 mg injections) SQ every 12 weeks	QS	0
<input type="checkbox"/> Stelara <input type="checkbox"/> 45 mg PFS (<100 kg) <input type="checkbox"/> 90 mg PFS (>100 kg)	<input type="checkbox"/> <b>Loading dose:</b> Inject one PFS SQ initially, one 4 weeks later, then once every 12 weeks <input type="checkbox"/> <b>Maintenance dose:</b> Inject one PFS SQ every 12 weeks	2	0
<input type="checkbox"/> Taltz <input type="checkbox"/> 80 mg PFS <input type="checkbox"/> 80 mg Autoinjector	<input type="checkbox"/> <b>Loading dose:</b> Inject 160mg SQ once, then 80mg weeks 2, 4, 6, 8, 10, and 12, then maint. <input type="checkbox"/> <b>Maintenance dose:</b> Inject 80 mg SQ every 4 weeks	8	0
<input type="checkbox"/> Tremfya <input type="checkbox"/> 100 mg PFS <input type="checkbox"/> 100 mg One-Press injector	<input type="checkbox"/> <b>Loading dose:</b> Inject 100 mg SQ on weeks 0 and 4, then every 8 weeks thereafter <input type="checkbox"/> <b>Maintenance dose:</b> Inject 100 mg SQ every 8 weeks	2	0
<input type="checkbox"/> Other			

Patient is ready to start treatment, contact patient for delivery  Ship all orders to office  Ship first order to office, subsequent orders to patient

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

*Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified*