ABD
Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

DERMATOLOGY ENROLLMENT FORM

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address: Phone: Alt Phone:

Height: Weight: Allergies :

DIAGNOSIS

☐ Psoriasis (L40.0)
☐ Atopic Dermatitis unspecified (L20.9)
☐ Hidradenitis suppurativa (L73.2)
☐ Other:

_____ % BSA affected by psoriasis
Affected areas include palms, soles, head, neck, or genitalia: ☐ Yes ☐ No
Additional justification for drug:

CLINICAL INFORMATION

Treatment history:
☐ New start ☐ Restart ☐ Continuing therapy ☐ Drug change

Failed therapies:
☐ Enbrel ☐ Humira ☐ Stelara ☐ Remicade ☐ MTX
☐ PUVA ☐ UVB ☐ Topicals

Date of TB test: _____ **Results:** ☐ negative ☐ pending
Current therapy: _____
Stop before starting new therapy? ☐ Yes ☐ No
Withhold for how long before starting: _____

DRUG		DIRECTIONS	QTY	REF
☐ **Cimzia**	☐ 200 mg **vial** ☐ 200 mg **PFS**	☐ Inject 400 mg (two 200 mg injections) SQ every other week		
☐ **Cosentyx**	☐ 150 mg **PFS** ☐ 150 mg **Sensoready pen**	☐ **Loading dose:** Inject 300mg (two 150 mg injections) SQ at weeks 0, 1, 2, 3, & 4, then maint. ☐ **Maintenance dose:** Inject 300 mg (two 150 mg injections) SQ every 4 weeks	QS	0
☐ **Dupixent**	☐ 300 mg **PFS** ☐ 300 mg **Pen**	☐ **Loading dose:** Inject 600 mg (two 300 mg injections) SQ once, then maintenance ☐ **Maintenance dose:** Inject 300 mg SQ every other week	2	0
☐ **Enbrel**	☐ 25 mg **vial** ☐ 25 mg **PFS** ☐ 50 mg **PFS** ☐ 50 mg **Sureclick pen** ☐ 50 mg **Mini cartridge**	☐ **Plaque psoriasis loading dose:** Inject 50 mg SQ twice a week (72-96h apart) for 3 months, then begin maintenance dose ☐ **Maintenance dose:** Inject 50 mg SQ once weekly **Office must supply autoinjector device for Enbrel Mini Device*	24	0
☐ **HUMIRA** Citrate Free	☐ Humira Psoriasis loading dose **Pen** Kit ☐ Humira HS loading dose **Pen** Kit ☐ 40 mg **Pen** ☐ 40 mg **PFS**	**Psoriasis** ☐ **Loading dose:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week ☐ **Maintenance dose:** Inject 40 mg SQ every other week **Hidradenitis suppurativa** ☐ **Loading dose:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg starting on day 29 ☐ **Maintenance dose:** Inject 40 mg SQ every week		0 0
☐ **Ilumya**	100 mg **PFS**	☐ **Loading dose:** Inject 100 mg SQ at weeks 0 and 4, then begin maintenance ☐ **Maintenance dose:** Inject 100 mg SQ every 12 weeks	2	0
☐ **Otezla**	☐ 10/20/30 **titration pack** ☐ 30 mg **tablets**	☐ **Loading dose:** Take as directed on titration pack ***or*** Given by office on ___/___/___ ☐ **Maintenance dose:** Take 1 tablet PO BID	55	0
☐ **Siliq**	☐ 210 mg **PFS**	☐ **Loading dose:** Inject 210 mg SQ on weeks 0, 1, and 2, then once every 2 weeks ☐ **Maintenance dose:** Inject 210 mg SQ every 2 weeks	2	0
☐ **Skyrizi**	☐ 150 mg **Pen** ☐ 150 mg **PFS**	☐ **Loading dose:** Inject 150 mg SQ at weeks 0 and 4, then begin maintenance dose ☐ **Maintenance dose:** Inject 150 mg SQ every 12 weeks	QS	0
☐ **Stelara**	☐ 45 mg **PFS (<100 kg)** ☐ 90 mg **PFS (>100 kg)**	☐ **Loading dose:** Inject one PFS SQ initially, one 4 weeks later, then once every 12 weeks ☐ **Maintenance dose:** Inject one PFS SQ every 12 weeks	2	0
☐ **Taltz**	☐ 80 mg **PFS** ☐ 80 mg **Autoinjector**	☐ **Loading dose:** Inject 160mg SQ once, then 80mg weeks 2, 4, 6, 8, 10, and 12, then maint. ☐ **Maintenance dose:** Inject 80 mg SQ every 4 weeks	8	0
☐ **Tremfya**	☐ 100 mg **PFS** ☐ 100 mg **One-Press injector**	☐ **Loading dose:** Inject 100 mg SQ on weeks 0 and 4, then every 8 weeks thereafter ☐ **Maintenance dose:** Inject 100 mg SQ every 8 weeks	2	0
☐ **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