



DERMATOLOGY ENROLLMENT FORM

FAX REFERRAL TO: 1-888-801-0404
PHONE: 1-888-570-9077

Date: _____

• Ship to: Patient Office

Needs by Date: _____

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Name: _____
 Address: _____
 City, State, Zip: _____
 Cell Phone: _____
 Home Phone: _____
 SS#: _____
 Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 DEA #: _____ NPI #: _____
 Group/Hospital: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____

INSURANCE INFORMATION

Primary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)
Secondary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)

DIAGNOSIS / ICD 10 CODE

ALLERGIES

PRIOR FAILED MEDICATIONS/CONCOMITANT DISEASES

(PLEASE LIST)

<input type="checkbox"/> Topical Steroids	<input type="checkbox"/> Other:
<input type="checkbox"/> PUVA	<input type="checkbox"/> Other:
<input type="checkbox"/> UVB	<input type="checkbox"/> Other:
<input type="checkbox"/> Cyclosporine	<input type="checkbox"/> Other:
<input type="checkbox"/> Oral Retinoids	<input type="checkbox"/> Other:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

PRESCRIPTION INFORMATION

MEDICATION		FREQUENCY/DIRECTIONS FOR USE	QUANTITY	REFILL
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50 MG Syringe <input type="checkbox"/> 50 MG Sureclick	<input type="checkbox"/> 50mg twice a week for 3 months then 50mg once a week thereafter <input type="checkbox"/> 50mg once a week <input type="checkbox"/> Other:		
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Psoriasis Starter <input type="checkbox"/> 40 MG Syringe <input type="checkbox"/> 40 MG Pen	<input type="checkbox"/> 80mg initial dose, then 40mg every other week starting one week after initial dose <input type="checkbox"/> 40mg every other week <input type="checkbox"/> Other:		
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45 MG Syringe <input type="checkbox"/> 90 MG Syringe	For patients <100 kg, administer: <input type="checkbox"/> Initial dose of 45mg at week 0 and week 4 followed by: <input type="checkbox"/> Maintenance dose of 45mg every 12 weeks For patients >100 kg, administer: <input type="checkbox"/> Initial dose of 90mg at week 0 and week 4 followed by: <input type="checkbox"/> Maintenance dose of 90mg every 12 weeks		
<input type="checkbox"/> REMICADE®	<input type="checkbox"/> 100 MG Vial	<input type="checkbox"/> For new start, give 5mg/kg at 0, 2, and 6 weeks <input type="checkbox"/> For continuing therapy, give 5mg/kg every 8 weeks Patient Weight _____ kg		
<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> 30 mg Tablet <input type="checkbox"/> Titration Starter pack	<input type="checkbox"/> Maintenance dose: 30 mg tablet twice daily <input type="checkbox"/> Titration Starter pack: As Directed		
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 50 mg Smartject <input type="checkbox"/> 50 mg PFS	<input type="checkbox"/> Inject 50 mg subcutaneously once per month <input type="checkbox"/> Other:		
<input type="checkbox"/> COSENTYX®	<input type="checkbox"/> Sensoready Pen 300mg dose (2 pack) <input type="checkbox"/> PFS 300mg dose (2 pack) <input type="checkbox"/> Other:	<input type="checkbox"/> Psoriasis Loading dose: Inject 300mg (two injections) SC weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Psoriasis maintenance dose: Inject 300mg SC every 4 weeks <input type="checkbox"/> Other:		
<input type="checkbox"/> OTHER:				

I authorize Focus Rx staff or its representatives to act as an agent of prescriber to execute any prior authorization or appeal on my behalf.

 Prescriber Signature and Date