DERMATOLOGY ENROLLMENT FORM

FocusRx
Positive Patient Outcomes

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/CONCOMMITANT DISEASES
(PLEASE LIST)

☐ Topical Steroids	☐ Other:
☐ PUVA	☐ Other:
☐ UVB	☐ Other:
☐ Cyclosporine	☐ Other:
☐ Oral Retinoids	☐ Other:
☐ Methotrexate	☐ Other:
☐ Other:	☐ Other:

PRESCRIPTION INFORMATION

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