RESTORE RX SPECIALTY PHARMACY

Dermatology Enrollment Form A-N

Date:______________

Patient Data

Patient Name: ______________________ Birthdate: ____________ Sex: ❑ Male ❑ Female Height: ______ Weight: ______ lbs kg

SSN #: XXX-XX-______________ Known Allergies: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Primary Language: ______________________

Authorized Contact: ______________________ Contact's Phone: ______________________

Ins. Data

Primary Insurance: ______________________ Secondary Insurance: ______________________

ID: ______________________ Group#: ____________ ID: ______________________ Group#: ____________

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Diagnosis: ______________________ **ICD 10 code:** ____________ **Date of Diagnosis (or years with disease):** ____________

Severity: ☐ Moderate ☐ Moderate to Severe ☐ Severe **Does patient have a latex allergy?** ☐ Yes ☐ No

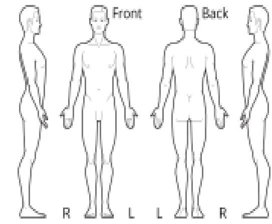
____________ % BSA affected by Psoriasis

Has patient received PPD (tuberculosis) skin test? Yes No Date: ____________ Results: ☐ Positive ☐ Negative

Has patient been tested for Hepatitis B? ☐ Yes ☐ No **If positive, has treatment been initiated?** ☐ Yes ☐ No

Has patient previously been treated for this condition? ☐ Yes ☐ No Injection Training Needed? ☐ Yes ☐ No

If yes, medication/therapy failed (length of therapy): ______________________



Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ 200mg/ml PFS ☐ 200mg/ml vial	☐ Induction: Inject 400mg SQ on days 0, 14, 28	#6	0 refills
		☐ Maintenance: Inject 400mg SQ every 28 days ☐ Maintenance: Inject 200mg SQ every 14 days		
☐ Cosentyx®	☐ 150mg pen ☐ 150mg PFS	☐ Induction: 300mg (two injections) SQ at weeks 0, 1, 2, 3, 4	#10	0 refills
		☐ Maintenance: Inject 300mg (two injections) SQ every 28 days	#2	
☐ Dupixent®	300mg/2ml PFS	☐ Induction: Inject 600mg (two injections) SQ on day 0	#2	0 refills
		☐ Maintenance: Inject 300mg SQ every other week	#2	
☐ Enbrel®	☐ 50mg/ml PFS ☐ 50mg/ml SureClick™ Autoinjector ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml vial	☐ Induction: Inject 50mg SQ twice weekly for 3 months	#8	2 refills
		☐ Maintenance: Inject 50mg SQ every 7 days ☐ Other: ______________		
☐ Enbrel® Mini™ *AutoTouch™ device available only through RxCrossroads*	50mg/ml cartridge	☐ Induction: Inject 50mg SQ twice weekly for 3 months	#8	2 refills
		☐ Inject 50mg SQ every 7 days	#4	
☐ Humira®	☐ Psoriasis Starter Package	☐ Induction: Inject 80mg (two injections) SQ on day 1, then one 40mg pen on day 8, then one 40mg pen every other week	1 package	0 refills
	☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml pen	☐ Maintenance: Inject 40mg SQ every other week	#2	
☐ Humira® *Citrate Free*	☐ Psoriasis Starter Package (pens only) 1-80mg/0.8ml and 2-40mg/0.4ml	☐ Induction: Inject 80mg (1 injection) SQ on day 1; Inject 40mg (1 injection) SQ on day 8 and day 22	#3	0 refills
	☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml pen	☐ Maintenance: Inject 40mg SQ every other week	#2	
☐ Ilumya™	100mg/1ml PFS	☐ Induction: Inject 100mg SQ on weeks 0 and 4	#2	0 refills
		☐ Maintenance: Inject 100mg SQ every 12 weeks	#1	

Is patient new to this therapy? ❑ YES ❑ NO | **Ship to:** ❑ Patient ❑ Office ❑ Other | **Desired Start Date:** ____________

Prescriber Data

Prescriber Name: ______________________ DEA#: ____________ NPI: ____________

Practice Name: ______________________ Contact: ____________ Preferred Method: ❑ Phone ❑ Fax ❑ Email

Address: ______________________ Phone: ____________ Fax: ____________

City: ____________ State: ____________ Zip: ____________ Email: ______________________

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: ______________________ Date: ____________

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.