Dermatology Enrollment Form O-Z

RESTORE Rx SPECIALTY PHARMACY

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Authorized Contact: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Contact's Phone: _____

Ins. Data

Primary Insurance: _____
ID: _____ Group#: _____

Secondary Insurance: _____
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):** _____

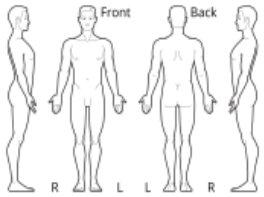
Severity: ☐ Moderate ☐ Moderate to Severe ☐ Severe **Does patient have a latex allergy?** ☐ Yes ☐ No _____ % BSA affected by Psoriasis

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
☐ Orencia	☐ 125mg/ml ClickJect™ Autoinjector ☐ 125mg/ml PFS	Inject 125mg SQ once weekly	#4	
☐ Otezla®	☐ Titration Starter Pack	Day 1: 10mg in the morning Day 2: 10mg in the morning and in the evening Day 3: 10mg in the morning and 20mg in the evening Day 4: 20mg in the morning and in the evening Day 5: 20mg in the morning and 30mg in the evening Day 6 and thereafter: 30mg twice daily	1 pack	0 refills
	☐ 30mg tablet	☐ Maintenance: 30mg twice daily	#60	
☐ Siliq™	210mg PFS	☐ Induction: Inject 210mg SQ at weeks 0, 1, and 2	#3 syringes	0 refills
		☐ Maintenance: Inject 210mg SQ once every 2 weeks	#2 syringes	
☐ Simponi®	☐ 50mg/0.5ml SmartJect™ Autoinjector ☐ 50mg/0.5ml PFS	Inject 50mg SQ once monthly	#1	
☐ Skyrizi™	75mg/0.83ml PFS	☐ Induction: Inject 150mg (2 injections) SQ at weeks 0 and 4	#4 syringes	0 refills
		☐ Maintenance: Inject 150mg (2 injections) SQ every 12 weeks	#2 syringes	
☐ Stelara®	☐ 45mg/0.5ml PFS (<100kg)	☐ Induction: Inject 45mg SQ at days 0 and 28	#2 syringes	0 refills
		☐ Maintenance: Inject 45mg SQ every 12 weeks		
	☐ 90mg/ml PFS (>100kg)	☐ Induction: Inject 90mg SQ at days 0 and 28	#2 syringes	0 refills
		☐ Maintenance: Inject 90mg SQ every 12 weeks		
☐ Taltz®	☐ 80mg/ml Autoinjector	☐ Induction: Inject 160mg (2 injections) SQ at week 0, then inject 80mg (1 injection) at weeks 2, 4, 6, 8, 10, and 12	#8	0 refills
	☐ 80mg/ml PFS	☐ Maintenance: Injection 80mg SQ once every 4 weeks	#1	
☐ Tremfya®	100mg/ml PFS	☐ Induction: Inject 100mg SQ at weeks 0 and 4	#2	0 refills
		☐ Maintenance: Inject 100mg SQ every 8 weeks	#1	
☐ Xeljanz®	5mg tablet	Take 1 tablet orally twice daily	#60	
☐ Xeljanz® XR	11mg tablet	Take 1 tablet orally once daily	#30	

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

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
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.