



**Dermatology Enrollment Form
Patient Referral/Medication Request Form**

Phone: 806-324-5447 • Toll Free Phone 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

Patient Information

Patient Name _____

Date of Birth _____ Male Female

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone Home _____

Work _____ Cell _____

Social Security # _____

Allergies _____ NKA

Weight _____ kg lb

Emergency Contact Name _____

Phone _____

Please attach copy of insurance information or copy of insurance cards (both sides).

Shipping Information

Patient's Home Physician's Office

Other _____

Date Medication Needed _____

Physician Information

Physician Name _____

Office Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Physician Signature _____

Date _____

Dispense as written Generic substitution permitted

Diagnosis/Medical Information

ICD9 Code:

696.0 Psoriatic Arthropathy 696.1 Other Psoriasis

Other (include code) _____

Severity: Moderate Moderate to Severe Severe

Type: Plaque Other (please specify): _____

Prior (FAILED) Medications: Biologics Methotrexate Oral Meds PUVA

UVB Topicals Other: _____

Injection Training/Home Health

Specialty Pharmacy to coordinate injection training

Home health nurse to visit as necessary. Injection training is not necessary.

Additional Comments: _____

Prescription Information

Amevive® (alefacept)

Initial Treatment Retreatment**

7.5mg IV once wkly for 12 weeks

15mg IM once wkly for 12 weeks

Other: _____

**Patients are only eligible for Retreatment if CD4+ lymphocyte counts are within normal limits and a minimum of a 12 week interval has passed since previous treatment course.

Humira® (adalimumab)

Initial Therapy

40mg/0.8ml Psoriasis Starter Kit (4 pens/box)

Two 40mg pens (80mg) followed by one 40mg pen every other week starting one week after the initial dose. Dispense #1 Kit; no refills

Maintenance Therapy

40mg/0.8ml, PEN (2 pens/box)

40mg/0.8ml, PFS (2 pfs/box)

Inject 40mg SC every other week

Other: _____

Dispense:

1 month supply 3 months supply

Refill _____ times

Enbrel® (etanersept)

25mg/0.5ml PFS 25mg vial

50mg/ml PFS 50mg/ml SURECLICK

50mg SC twice wkly (72-96 hours apart) for first 3 months

50mg SC once wkly after first 3 months

25mg SC twice wkly (72-96 hours apart)

Other: _____

Remicade® (infliximab)

Initial Therapy

5mg/kg IV given at 0, 2, & 6 weeks

Maintenance Therapy

5mg/kg IV every 8 weeks

Other: _____

Stalera™ (ustekinumab)

Initial Therapy

≤100kg (220lbs) 45mg SC; repeat dose in 4 weeks

>100kg (220lbs) 90mg SC; repeat dose in 4 weeks

Maintenance Therapy

≤100kg (220lbs) 45mg Q 12 wks starting at 16 wks

>100kg (220lbs) 90mg Q 12 wks starting at 16 wks

Need Supplies: Please specify _____

Ancillary supplies/kits provided as needed for administration.