DERMATOLOGY SPECIALTY ENROLLMENT

encore pharmacy

Fax to: 512-490-6515

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
Phone: 512-381-1708
Toll Free: 855-241-6658
11209 Metric Blvd., Suite B4
Austin, TX 78758

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐ MALE ☐ FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

DIAGNOSIS CODE

- ☐ L40.9 Psoriasis
- ☐ L40.52 Psoriatic Arthritis
- ☐ L73.2 Hidradenitis Suppurativa
- ☐ L20.9 Atopic Dermatitis
- ☐ Other _____

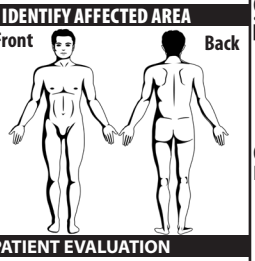
Date Of Diagnosis: _____
Or Years With Disease _____

PRIOR (FAILED) TREATMENTS

	Medication	Reason for D/C
☐ *Biologics:*	_____	_____
☐ *Methotrexate*	*NA*	_____
☐ *Oral Meds*	_____	_____
☐ *PUVA*	*NA*	_____
☐ *UVB*	*NA*	_____
☐ *Topicals*	_____	_____
☐ *Other*	_____	_____

IDENTIFY AFFECTED AREA

Front Back



PATIENT EVALUATION

%BSA affected: _____
Weight: _____ kg/lbs
TB ruled out? ☐ Yes ☐ No ☐ N/A
Hep B ruled out or being treated? ☐ Yes ☐ No ☐ N/A
Active infection? ☐ Yes ☐ No
Allergies: _____
☐ NKDA ☐ Latex

PRESCRIPTION INFORMATION

☐ CIMZIA®

☐ FOR PSORIATIC ARTHRITIS:

☐ Starter Dose:
☐ Starter Kit (200mg PFS)
☐ Vial (200mg/ml) & supplies

☐ Starter Directions:
☐ Inject 400mg SC at wks 0, 2, and 4
☐ Other: _____

QTY: ☐ 1 PFS KIT (6x200mg syr) ☐ 6 vials ☐ _____

☐ Maintenance Dose:
☐ Pre-filled Syringe (200mg/ml)
☐ Vial (200mg/ml) & supplies

☐ Maintenance Directions:
☐ Inject 200mg SC every *other* wk
☐ Inject 400mg SC every 4 weeks
☐ Other: _____

QTY: ☐ 2 PFS /vials
☐ _____ | **Refills** _____

☐ CIMZIA®

☐ FOR PSORIASIS:
☐ 200mg/ml PFS ☐ 200mg/ml vial

☐ Dosing:
☐ Inject 400mg SC every ***other*** week.
☐ Other: _____

QTY: ☐ 4 ☐ _____ | **Refills** _____

**NOTE: some pts weighing ≤ 90 kg may follow PsA dosing if sufficient*

☐ COSENTYX®

☐ PLAQUE PSORIASIS
☐ 150mg/ml PFS ☐ (1-pack) ☐ (2-pack)
☐ 150mg/ml Pen ☐ (1-pack) ☐ (2-pack)
☐ 75mg/0.5ml PFS (1-pack)

☐ Starter Dose:
Inject ☐ 300mg ☐ 150mg ☐ 75mg SC at Wk 0, 1, 2, 3, 4, then every 4 weeks thereafter.

QTY: ☐ 10 Pens / PFS ☐ 5 Pens / PFS

☐ Maintenance Dose:
☐ Inject 300mg SC every 4 weeks
☐ Inject 150mg SC every 4 weeks
☐ Inject 75mg SC every 4 weeks
☐ Other: _____

QTY: ☐ 2 Pens/PFS ☐ 1 Pens/PFS | **Refills** _____

☐ PSORIATIC ARTHRITIS
☐ 150mg/ml PFS ☐ (1-pack) ☐ (2-pack)
☐ 150mg/ml Pen ☐ (1-pack) ☐ (2-pack)

☐ Starter Dose:
Inject ☐ 300mg ☐ 150mg SC at wks 0,1, 2, 3, & 4, then 150mg SC every 4 wks thereafter.

QTY: ☐ 1 Pens / PFS ☐ 2 Pens / PFS

☐ Maintenance Dose:
☐ Inject 150mg SC every 4 weeks

QTY: ☐ 1 Pens/PFS | **Refills** _____

☐ DUPIXENT®

FOR ATOPIC DERMATITIS:

☐ Starter Dose:
☐ 300mg/2ml PFS ☐ 300mg/2ml Pen
☐ 200mg/1.14ml PFS

☐ Starter Directions:
☐ Inject 600mg (2PFS/Pens) SC on day 1, then 300mg (1PFS/Pen) SC every other week starting on day 15.
☐ Inject 400mg (2PFS/Pens) SC on day 1, then 200mg (1PFS/Pen) SC every other week starting on day 15.

QTY: ☐ 2 PFS/Pens ☐ _____

☐ Maintenance Dose:
☐ 300mg/2ml PFS ☐ 300mg/2ml Pens
☐ 200mg/1.14ml PFS

☐ Maintenance Directions:
☐ Inject 300mg (1 PFS/Pens) SC every other week.
☐ Inject 200mg (1 PFS) SC every other week

QTY: ☐ 2PFS/Pens ☐ ____ | **REFILLS** ____

☐ ENBREL®

☐ FOR PSORIASIS:
☐ SureClick Pen® (50mg/ml)
☐ 50mg/ml Pre-filled Syringe
☐ 25mg/0.5ml Pre-filled Syringe
☐ Vial (25mg/0.5ml)
☐ 50mg/ml Mini cartridge

☐ Psoriasis Starter Dose:
☐ Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing
☐ Other: _____

☐ Psoriasis Maintenance Dose:
☐ Inject 50mg SC ONCE a week
☐ Other: _____

☐ FOR PSORIATIC ARTHRITIS:

☐ Psoriatic Arthritis Dose:
☐ Inject 50mg SC ONCE a week
☐ Other: _____

QTY: ☐ 8 PFS/Pen ☐ 4 PFS/Pen
☐ _____ | **Refills** _____

☐ OTEZLA®

Use Otezla START form for bridge dosage

☐ Starter Dose:
☐ Starter / Titration Pack

☐ Starter Directions:
☐ Take as directed on Starter Pack

QTY: ☐ 1 Starter pack

☐ Maintenance Dose (30mg)

☐ Maintenance Directions:
☐ Take 1 tablet by mouth TWICE a day
☐ Take 1 tablet by mouth ONCE a day
☐ Other: _____

QTY: ☐ 30 ☐ 60 ☐ ____ | **REFILLS** _____

☐ HUMIRA®

☐ FOR PSORIASIS:

☐ Psoriasis Starter
☐ PS Starter Kit
☐ PS Starter Kit (citrate-free)

☐ Psoriasis Starter Dose
☐ Inject 80mg SC on Day 1, then 40mg SC on Day 8, then maintenance dosing
☐ Other: _____

QTY: ☐ 1 Starter Package

☐ Psoriasis Maintenance Dose:
☐ 40mg/0.8ml pen ☐ 40mg/0.8ml PFS
☐ 40mg/0.4ml pen (citrate-free) ☐ 40mg/0.4ml PFS (citrate-free)

☐ Psoriasis Maintenance Directions:
☐ Inject one 40mg dose SC every other wk

QTY: ☐ _____ | **Refills** _____

☐ FOR PSORIATIC ARTHRITIS:

☐ Psoriatic Arthritis Directions:
☐ Inject one 40mg dose SC every other wk
☐ Other: _____

QTY: ☐ 2 Pens/PFS
☐ _____ | **Refills** _____

☐ HUMIRA®

☐ FOR HIDRADENITIS SUP.:

☐ Hidradenitis Sup. Starter
☐ HS Starter Kit
☐ HS Starter Kit (citrate-free)

☐ Hidradenitis Sup. Starter Dose
☐ Inject 160mg SC on Day 1, then 80mg on Day 15, then maintenance dosing..

QTY: ☐ 1 Starter Package

☐ Hidradenitis Sup. Maintenance Dose:
☐ 40mg/0.8ml pen ☐ 40mg/0.8ml PFS
☐ 40mg/0.4ml pen (citrate-free) ☐ 40mg/0.4ml PFS (citrate-free)

☐ Hidradenitis Su. Maintenance Directions:
☐ Inject 40mg SC ONCE a week.
☐ Other: _____

QTY: ☐ 4 Pens/PFS
☐ _____ | **Refills** _____

☐ SIMPONI®

☐ 50mg/0.5ml SmartJect® (Pen)
☐ 50mg/0.5ml Pre-filled Syringe

☐ Directions:
☐ Psoriatic Arthritis Dose: Inject 50mg (0.5ml) SC once a month
☐ Other: _____

QTY: ☐ 1 Pen ☐ 1 Pre-fill Syr
☐ _____ | **Refills** _____

☐ STELARA®

☐ Dose: ☐ 45mg/0.5ml Pre-filled Syringe
☐ 90mg/1ml Pre-filled Syringe

☐ Starter Directions:
☐ Inject 1 pre-filled syringe SC on Day 1
☐ Other: _____

QTY: ☐ 1 Pre-filled syringe ☐ _____

☐ Maintenance Directions:
☐ Inject 1 pre-filled syringe SC four weeks after start of treatment, then every 12 weeks thereafter
☐ Inject 1PFS SC every 12 weeks
☐ Other: _____

QTY: ☐ 1 Pre-filled Syr ☐ 2 Pre-filled Syr
☐ _____ | **Refills** _____

☐ SKYRIZI™

☐ 150mg/ml Pen ☐ 150mg/ml PFS
☐ 75mg/0.83ml PFS

☐ Starter Directions:
☐ Inject 150mg SC at Week 0, 4, then every 12 weeks thereafter.

QTY: ☐ 1 Pack | ☐ **1 Refill**

☐ Maintenance Directions:
☐ Inject 150mg SC every 12 weeks

QTY: ☐ 1 Pack | **Refills** _____

Is patient enrolled in product manufacturer-sponsored support program? (ex. myHUMIRA, Enbrel support™)
☐ *Yes* ☐ *No*

☐ TALTZ®

☐ 80mg Pre-filled Syringe
☐ 80mg Pen

☐ PLAQUE PSORIASIS:

☐ Starter Dose
☐ Inject 160mg (2 pens/PFS) SC at week 0, followed by 80mg (1 pen/PFS) at weeks 2, 4, 6, 8, 10, and 12.

☐ Maintenance Dose
☐ Inject 80mg SC every 4 weeks
☐ Other: _____

QTY: ☐ 1-month supply
☐ 3-month supply
☐ _____ | **Refills** _____

☐ PSORIATIC ARTHRITIS:

☐ Starter Dose
☐ Inject 160mg (2 pens/PFS) SC at week 0, followed by 80mg (1 pen/PFS) SC every 4 weeks.

☐ Maintenance Dose
☐ Inject 80mg SC every 4 weeks.
☐ Other: _____

QTY: ☐ 1-month supply
☐ 3-month supply
☐ _____ | **Refills** _____

**NOTE: For psoriatic arthritis patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis.*

☐ TREMFYA™

☐ 100mg/ml PFS
☐ 100mg/ml Autoinjector Pen

☐ Starter Directions:
☐ Inject 100mg SC at Week 0, then start maintenance dosing at Week 4.

☐ Maintenance Directions:
☐ IInject 100mg SC every 8 weeks (Start maintenance at Week 4).
☐ Other: _____

QTY: ☐ 1 PFS ☐ 1PFS/Pen | **Refills** _____

☐ XELJANZ®

☐ 5mg Tablet

☐ Directions:
☐ Take 5mg PO twice daily.
☐ Other: _____

QTY: ☐ 60 ☐ _____ | **Refills** _____

☐ XELJANZ XR®

☐ 11mg Tablet

☐ Directions:
☐ Take 1 tablet PO once daily.
☐ Othr: _____

QTY: ☐ 30 ☐ _____ | **Refills** _____

☐ OTHER

Drug Name: _____
☐ Strength: _____
☐ Directions: _____

QTY: ☐ _____ | **Refills** _____

INJECTION TRAINING ☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI # : _____ DEA # : _____ TAX ID # : _____ Medicaid Provider # : _____

_____ _____ * _____
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Form: © REF--Derm-E-Encore 83 -5010-12-29-22