DERMATOLOGY SPECIALTY ENROLLMENT
Fax to: 512.490.6515

HepCare Specialty Pharmacy
Committed • Accessible • Reliable • Experienced

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
2200 Park Bend Dr. Bldg. 1, Suite 300
Austin , TX 78758
Phone: 512.381.1708
Toll Free: 855-241-6658

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)

PRESCRIPTION INFORMATION

CLINICAL INFORMATION

Diagnosis Code
- ☐ L40.9 Psoriasis
- ☐ L40.52 Psoriatic Arthritis
- ☐ L73.2 Hidradenitis Suppurativa
- ☐ Other _____

Date Of Diagnosis: _____
Or Years With Disease _____

Assessment of the Past 12 Months

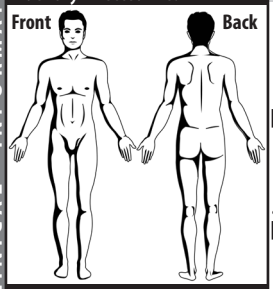
Psoriasis Severity: ☐ *Moderate* ☐ *Moderate to Severe* ☐ *Severe*
Type: ☐ *Plaque* ☐ *Other, please specify:* _____

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

Has patient been diagnosed with heart failure? ☐ Yes ☐ No
Does patient have a latex allergy? ☐ Yes ☐ No
Has patient been diagnosed with Lymphoma? ☐ Yes ☐ No
Has TB test been performed? ☐ Yes ☐ No
If Yes, results: _____
Comments: _____
Is patient's platelet count >52,000 cells/uL? ☐ Yes ☐ No
Patient Weight: _____ kg/lbs
% BSA affected by psoriasis: _____
Does the patient have a serious/active infection? ☐ Yes ☐ No
Has Hepatitis B been ruled out? ☐ Yes ☐ No
If no, has treatment been initiated? ☐ Yes ☐ No

☐ Cimzia®

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

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

QTY: ☐ 1 pre-filled syr KIT (6x200mg syr) ☐ 6 vials ☐ _____

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

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

QTY: ☐ 2 pre-filled syr ☐ 4 vials ☐ _____ | **Refills** _____

☐ Enbrel®

☐ For Psoriasis
- ☐ SureClick Pen® (50mg/ml)
- ☐ 50mg/ml Pre-filled Syringe
- ☐ 25mg/0.5ml Pre-filled Syringe
- ☐ Vial (25mg/0.5ml)

☐ Psoriasis Induction 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
- ☐ Psoriasis Starter Package

☐ Psoriasis Induction Dose
- ☐ Inject two 40mg Pens SC on day 1, then one 40mg Pen on day 8, then one 40mg Pen every other week
- ☐ Other: _____

QTY: ☐ 1 Starter Package

☐ Psoriasis Maintenance Dose:
- ☐ Pen (40mg/0.8ml)
- ☐ 40mg/0.8ml Pre-filled Syringe

☐ 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 PFS/pen ☐ 4 PFS/Pen ☐ _____ | **Refills** _____

☐ Humira®

☐ For Hidradenitis Sup.

☐ Hidradenitis Sup. Starter
- ☐ Starter Package (same as Crohn's Disease)

☐ Hidradenitis Sup. Induction Dose
- ☐ Inject 4 pens (160mg) SC on Day 1, then 2 pens (80mg) two weeks later on Day 15, then 1 pen (40mg) ONCE a week starting on day 29.

QTY: ☐ 1 Starter Package

☐ Hidradenitis Sup. Maintenance Dose:
- ☐ Pen (40mg/0.8ml)
- ☐ 40mg/0.8ml Pre-filled Syringe

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

QTY: ☐ 4 Pre-filled syr/pen ☐ _____ | **Refills** _____

☐ Remicade®
- ☐ Vial (100mg/20ml)

☐ Initial Directions:
- ☐ Administer _____mg/kg at 0, 2, & 6 weeks, then q 8 weeks

QTY: ☐ _____ Vials

☐ Maintenance Directions:
- ☐ Administer _____mg/kg every _____ weeks
- ☐ Other: _____

QTY: ☐ _____ Vials | **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

☐ Initial 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 1 pre-filled syringe SC every 12 weeks
- ☐ Other: _____

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

☐ Cosentyx®

☐ For Plaque Psoriasis -OR- Psoriatic Arthritis WITH Coexistent Psoriasis:
- ☐ 150mg/ml PFS (2-pack)
- ☐ 150mg/ml Pen (2-pack)

☐ Induction Dose:
- ☐ Inject 300mg SC weekly at weeks 0,1, 2, 3, and 4, then maintenance dosing.

QTY: ☐ 10 pens / PFS

☐ Maintenance Directions:
- ☐ Inject 300mg SC every 4 weeks.
- ☐ Other: _____

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

☐ For Psoriatic Arthritis:
- ☐ 150mg/ml PFS
- ☐ 150mg/ml Pen

☐ Induction Dose:
- ☐ Inject 150mg SC weekly at weeks 0,1, 2, 3, and 4, then maintenance dosing.

QTY: ☐ 5 pens / PFS

☐ Maintenance Directions:
- ☐ Inject 150mg SC every 4 weeks..
- ☐ Other: _____

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

☐ Other

Drug Name: _____

- ☐ Strength: _____
- ☐ Directions: _____

_____
_____
_____

QTY: ☐ _____ | **Refills** _____

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

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-HepCare -5010-10-1-2016