Dermatology Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Pharmacy Phone: 866-778-8255
Fax: 800-432-6614
pharmacy@skyemed.com

Deliver Medications To: ☐ **Patient's Home** ☐ **Doctors Office** **Date Needed By:** _____ **Injection Training** **Y** **N**

Patient Demographics

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Prescription Insurance: (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT"S CARD)

Primary Prescription Insurance: _____ RX BIN #: _____ RX PCN#: _____

Patient ID/Policy Number: _____ Patient RX Group Number: _____

Patient Clinical Information/History: (Please attach a copy of patient's recent chart notes, pathology, and labs)

Diagnosis: _____ ICD10 Code: _____ Severity: ☐ Moderate ☐ Severe Patient's weight: _____

TB Test: Yes No Result: _____ Date: _____ Sex: M F

Does patient have active/serious infection: Yes No

_____%BSA AFFECTED BY PSORIASIS _____# OF JOINTS AFFECTED BY PSA Drug Allergies: _____

Previous/Failed Medications: Date and Duration of Therapy: Reason for Discontinuation:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Prescription Information

Drug	Strength	Directions	Qty	Refill
☐ **Otezla**	☐ Starter Pak ☐ 30mg Tablet	Take 10mg by mouth on Day 1, and increasing by 10mg daily until taking 30mg twice daily thereafter		
☐ **Enbrel**	☐ 50mg/ml Sureclick ☐ 50mg/ml PFS ☐ 25mg /ml	☐ *Induction Dose:* Inject 50mg SQ 2 times a week for ___ months, then maintenance dose	3 boxes	0
		☐ *Maintenance Dose:* Inject 50mg SQ once a week		
		☐ *Other:*		
☐ **Humira**	☐ Psoriasis Starter Pack	☐ *Psoriasis Induction Dose:* Inject 80mg SQ day 1, 40mg on day 8, then maintenance dose	1 kit	0
		☐ *HS Induction Dose:* Inject 160mg SQ Day 0 (or 80mg on Day 1 and 2), 80mg on Day 15, 40mg on Day 29 then maintenance dose		
	☐ 40mg Pen ☐ 40mg PFS	☐ *Maintenance Dose:* Inject 40mg SQ every other week		
		☐ *Other:* _____		
Remicade Pt Wt ____kg	100mg Vial	Infuse ___(mg/kg) IV at weeks 0, 2 and 6 then ___mg/kg Q __ weeks Premeds: _____		
☐ **Simponi (only for PsA)**	☐ 50 Smartject ☐ 50mg PFS	Inject 50mg SQ once a month		
☐ **Stelara**	☐ 45mg PFS ☐ 90mg PFS	☐ *Induction Dose:* Inject 1 syringe SQ on day 1, then 1 syringe on day 28	2 PFS	0
		☐ *Maintenance Dose:* Inject 1 syringe SQ every 12 weeks		

Prescriber Information:

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: **Office Fax:** **Office Contact:**

DEA: NPI: UPIN: State License:

Physician Signature: _____ **Date:** _____

***If Physician requests brand name only, "Brand Medically Necessary" Must be handwritten below:**