Dermatology
Enrollment Form:
A-E

InfuCare Rx

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

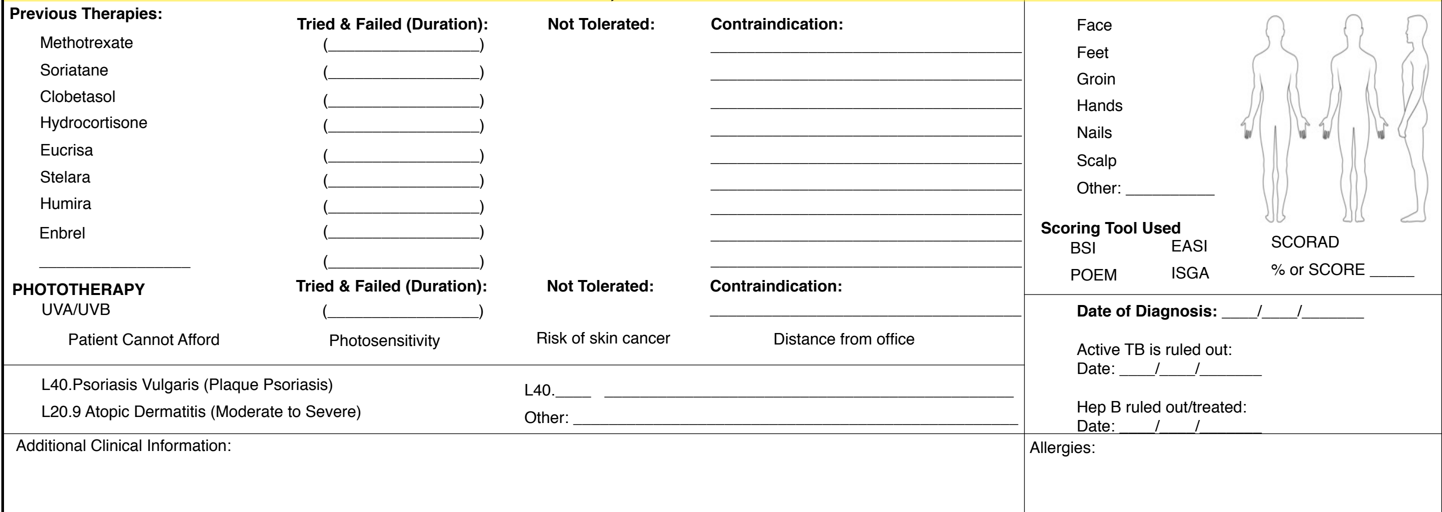
PATIENT INFORMATION				PRESCRIBER INFORMATION		
Name:		SSN#:		Prescribing Practitioner:		NPI:
Address:				Address:		
City:	State/Zip:			City		State/Zip
Telephone:	DOB:		M F	Office:		DEA:
Language Preference:		Wt:	Ht:	Contact:	Phone:	Fax:

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

PRESCRIPTION

New Refill | Ship by: | Ship to: Patient's Home Doctor's Office Other:________________________

Drug		Directions and Quantity	Refills
Cimzia®	Pre-filled Syringe Vials	(with body weight ≤ 90 kg), a dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at Weeks 2 and 4, followed by 200 mg every other week. **INITIAL:** Inject 400 mg SQ (two 200 mg injections) every other week (Quantity: 4)	
Cosentyx™	150 mg Sensoready Pen 150 mg Pre-filled Syringe	**INITIAL:** Inject 150 mg SQ on week 0,1, 2, 3, and 4, then maintenance dose (Qty: 10) **MAINTENANCE**: Inject 150 mg SQ every 4 weeks (Qty: 2)	
		INITIAL: Inject 300 mg (two 150 mg injections) SQ on week 0,1, 2, 3, and 4, then maintenance dose (Qty: 10) **MAINTENANCE**: Inject 300 mg (two 150 mg injections) SQ every 4 weeks (Qty: 2)	
Dupixent®	☐ Pre-filled Syringe	**ADULT:** **INITIAL:** Inject 600 mg SQ (two 300 mg injections in different injection sites) **MAINTENANCE**: Inject 300 mg SQ every **other** week	
Enbrel®	SureClick® Pen Mini™ with AutoTouch™ Pre-filled Syringe 25 mg 50 mg Vials 25 mg	**ADULT:** **INITIAL:** Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) **MAINTENANCE:** Inject 50 mg SQ weekly (Quantity 4)	
		PEDIATRIC: *****WEIGHT REQUIRED***** ________ Inject ____ mg (0.8 mg/kg x ___kg SQ every week) **(Less than or equal to 63 kg)** (Quantity: QS 1 month) Inject 50 mg SQ every week **(Greater than 63 kg)** (Quantity: 4)	



MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
Methotrexate	(_______________)		____________________
Soriatane	(_______________)		____________________
Clobetasol	(_______________)		____________________
Hydrocortisone	(_______________)		____________________
Eucrisa	(_______________)		____________________
Stelara	(_______________)		____________________
Humira	(_______________)		____________________
Enbrel	(_______________)		____________________
_______________	(_______________)		____________________

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
UVA/UVB	(_______________)		____________________

Patient Cannot Afford Photosensitivity Risk of skin cancer Distance from office

Face
Feet
Groin
Hands
Nails
Scalp
Other: __________

Scoring Tool Used
BSI EASI SCORAD
POEM ISGA % or SCORE _____

Date of Diagnosis: ____/____/_______

Active TB is ruled out:
Date: ____/____/_______

Hep B ruled out/treated:
Date: ____/____/_______

L40.Psoriasis Vulgaris (Plaque Psoriasis)
L20.9 Atopic Dermatitis (Moderate to Severe)

L40.____ ____
Other: ____

Additional Clinical Information:

Allergies:

AMERICAN ACADEMY OF DERMATOLOGY CONSENSUS STATEMENT ON PSORIASIS THERAPIES

Psoriasis is covering greater than 10% body surface area
Psoriasis is on palms, soles, head & neck, or genitals
Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment, or interpersonal relationships

INJECTION TRAINING

Patient has received pen and injection training
Physician's office to provide injection training
FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	Date:

Revised 8/2020