Dermatology Enrollment Form: Humira

InfuCare Rx

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

PATIENT INFORMATION

Name:
Address:
City: State/Zip:
Telephone: DOB: M ☐ F ☐
Language Preference: Wt: Ht:

PRESCRIBER INFORMATION

Prescribing Practitioner: NPI:
Address:
City: State/Zip:
Office: DEA:
Contact: Phone: Fax:

PRIMARY INSURANCE INFORMATION

Member Name: M ☐ F ☐ DOB:
Address: City:
State: Zip: Telephone: Alt. Telephone:
Member ID: Rx Group #: BIN#:
PCN#: Customer Service #:

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	Refills
Humira® Citrate Free	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADOLESCENT:** ****WEIGHT REQUIRED*****_____ ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4) ****Intended for weight > 60 kg/132 lbs*****_____	
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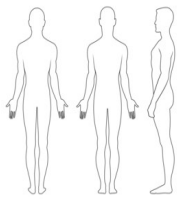
MEDICAL INFORMATION

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ Eucrisa	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ Face
☐ Feet
☐ Groin
☐ Hands
☐ Nails
☐ Scalp
☐ Other: _____



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

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA/UVB	☐ (_____)	☐	_____

☐ Patient Cannot Afford ☐ Photosensitivity ☐ Risk of skin cancer ☐ Distance from office

Date of Diagnosis: _____
Allergies: _____

Active TB is ruled out: ☐
Date: _____
Hep B ruled out/treated: ☐
Date: _____

☐ L40.Psoriasis Vulgaris (Plaque Psoriasis)
☐ L73.2 Hidradenitis suppurativa
☐ L40.____ _____
☐ Other: _____

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

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

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: **Date:**