InfuCare Rx

Dermatology Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ L20.89 Atopic Dermatitis
☐ L73.2 Hidradenitis
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ Other: _____
Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____
Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary: ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SUBQ at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	
☐ Cosentyx®	☐ 300mg (2x150) Pen ☐ PFS ☐ 150mg Pen ☐ PFS	☐ Load: Inject ☐ 300mg or ☐ 150mg SUBQ week 0,1,2,3,4 ☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SUBQ every 4 weeks	5 week supply 4 week supply	
☐ Dupixent®	☐ 300mg per 2mL PFS	☐ Inject 600mg (two 300mg injections in different injection sites) SUBQ on day 0, then 300mg day 14 and day 28 ☐ Inject 300mg SUBQ every other week	1 month supply	
☐ Enbrel®	☐ 50mg Sureclick ☐ 25mg Vials ☐ 50mg PFS ☐ 25mg PFS	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg twice weekly	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SUBQ once a week ☐ Inject 40mg SUBQ every other week ☐ Inject 80mg day 1, then 40mg day 8, then 40mg every other week ☐ Inject 160mg day 1, then day 15 inject 80mg, then starting day 29 inject 40mg every week	1 month supply	
☐ Otezla®	☐ 30mg tablet ☐ Starter Pack	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily ☐ Starter Pack: Take 1 tablet by mouth day 1, then take 1 tablet by mouth twice daily as directed	1 month supply	
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SUBQ once monthly	1 month supply	
☐ Stelara®	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45mg day 1 and week 4, then every 12 weeks ☐ Inject 45mg every 12 weeks ☐ Inject 90mg day 1 and week 4, then every 12 weeks ☐ Inject 90mg every 12 weeks	1 month supply	
☐ Tremfya™	☐ 100mg PFS	☐ Inject 100mg SUBQ on week 0 and week 4 ☐ Inject 100mg SUBQ every 8 weeks	1 month supply	
☐ Other:				

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____