InfuCare Rx®

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

Dermatology Enrollment Form

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

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:**__________

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