



Dermatology Intake Form

Northborough, MA: Toll free (855) 880-1091 Toll free fax (844) 265-0265

www.AllCarePlusPharmacy.com

DATE: _____ THERAPY START DATE: _____ DELIVERY : PATIENT OFFICE OTHER: _____

PATIENT INFO				
Patient Name				
Address				
City, State, Zip				
Phone		Social Security		
Date of Birth	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Hgt.	Wt.

PRESCRIBER INFO	
Prescriber Name	DEA/NPI #
Preparer Name/Office Contact	
Address	
City, State, Zip	
Phone	Fax

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

ICD-10 Code: _____
 Other ICD-10 Code: _____ Diagnosis: _____
 PATIENT ALLERGIES: _____
 Body Surface Area Affected: _____ % Location of Involvement: _____

Has patient received a PPD (tuberculosis) Skin Test? Yes No
 Results: _____
 Has patient been treated previously for this condition? Yes No
 Medication(s): _____
 Is this patient currently on therapy? Yes No
 Medication(s): _____

PRESCRIPTION INFORMATION

MEDICATION DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> CIMZIA® 200mg/mL Prefilled Syringe <input type="checkbox"/> CIMZIA® 200mg vial	<input type="checkbox"/> Induction Dose: Inject 400mg subcutaneously on day 1, at week 2, and at week 4 <input type="checkbox"/> Maint. Dose: Inject 200mg subcutaneously every OTHER week <input type="checkbox"/> Maint. Dose: Inject 400mg subcutaneously every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 kit (6 PFS) <input type="checkbox"/> _____ boxes (2 injects ea.) <input type="checkbox"/> 4 weeks supply	_____
<input type="checkbox"/> COSENTYX™ 150 mg Sensoready® Pen Kit <input type="checkbox"/> COSENTYX™ 150 mg Prefilled Syringe Kit	<input type="checkbox"/> Induction Dose: Inject 300mg subcutaneously week 0,1,2,3,4 (Qty: 10) <input type="checkbox"/> Maint. Dose: Inject 300mg subcutaneously every 4 weeks (Qty: 28 days)	<input type="checkbox"/> 10 injection devices, no refills <input type="checkbox"/> 28 day supply	_____
<input type="checkbox"/> ENBREL® 25mg/0.5mL Prefilled Syringe <input type="checkbox"/> ENBREL® 25mg multiple-use vial <input type="checkbox"/> ENBREL® 50mg/mL Prefilled Syringe <input type="checkbox"/> ENBREL® 50mg/mL Sure Click Autoinjector	<input type="checkbox"/> Inject 0.8 mg/kg subcutaneously ONCE a week, with a maximum of 50 mg per week <input type="checkbox"/> Inject 50mg subcutaneously ONCE a week <input type="checkbox"/> Inject 25mg subcutaneously TWICE a week (72-96 hrs apart) <input type="checkbox"/> Other: _____	QTY: _____	_____
<input type="checkbox"/> HUMIRA® Psoriasis Starter Kit <input type="checkbox"/> HUMIRA® Pen 40mg/0.8mL <input type="checkbox"/> HUMIRA® 40mg/0.8mL Prefilled Syringe	<input type="checkbox"/> Inject 2-40mg (80mg) on Day 1, then 40mg on Day 8, then 40mg every other week <input type="checkbox"/> Inject _____mg subcutaneously every week <input type="checkbox"/> Enroll in Humira Complete <input type="checkbox"/> Inject _____mg subcutaneously every OTHER week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 weeks supply (1 pack contains 4 pens) <input type="checkbox"/> 28 day supply	_____
<input type="checkbox"/> ORENCIA® 250mg Vial <input type="checkbox"/> ORENCIA® 125mg Orencea Subcutaneous <input type="checkbox"/> ORENCIA® 125mg ClickJect Autoinjector	<input type="checkbox"/> Infuse _____mg in 100ml of 0.9% NaCl at weeks 0, 2 and 4 then every 4 weeks <input type="checkbox"/> After single IV loading dose, inject 125mg subcutaneously within a day followed by 125 mg subcutaneous injections every week thereafter <input type="checkbox"/> For patients unable to receive an IV loading dose, inject 125mg subcutaneously every week <input type="checkbox"/> For patients transitioning from IV infusion therapy to subcutaneous therapy, inject 125mg subcutaneously instead of the next scheduled IV dose followed by 125mg subcutaneous injections every week thereafter. <input type="checkbox"/> Inject 125mg subcutaneously every week <input type="checkbox"/> Other: _____	QTY: _____	_____
<input type="checkbox"/> OTEZLA® 30mg Tablets	<input type="checkbox"/> Starter (Titration) Pak - take as directed x 14 days <input type="checkbox"/> Enroll in Celgene Patient Support® <input type="checkbox"/> Maintenance Dose - 30 mg twice daily by mouth <input type="checkbox"/> Other: _____	QTY: _____	_____
<input type="checkbox"/> REMICADE® 100mg vial 100mg/mL _____ mg/kg	<input type="checkbox"/> Initial Dose (5mg/kg): _____ mg IV on: Week 0, Week 2, Week 6, then start maintenance dose <input type="checkbox"/> Maintenance (5mg/kg): _____ mg IV every _____ weeks for _____ infusions <input type="checkbox"/> Other: _____	<input type="checkbox"/> MD's Office Infusion	_____
<input type="checkbox"/> SIMPONI® SMARTJECT 50mg/ml <input type="checkbox"/> SIMPONI® 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 50mg (0.5ml) subcutaneously once a month <input type="checkbox"/> Other: _____	QTY: _____	_____
<input type="checkbox"/> SIMPONI ARIA INJECTABLE® 50 mg/4mL (12.5mg/mL) single use vial	<input type="checkbox"/> 2mg/kg intravenous infusion over 30 minutes at weeks 0 and 4, then every 8 weeks <input type="checkbox"/> Dilution of supplied SIMPONI ARIA solution with 0.9% w/v sodium chloride is required prior to administration	QTY: _____	_____
<input type="checkbox"/> STELARA™ 45mg/0.5ml prefilled syringe <input type="checkbox"/> STELARA™ 90mg/mL prefilled syringe	<input type="checkbox"/> For patients weighing < 100kg (220lbs): Inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks. <input type="checkbox"/> For patients weighing > 100kg (220lbs): Inject 90mg SC initially and 4 weeks later, followed by 90mg every 12 weeks.	QTY: _____	_____
<input type="checkbox"/> TALTZ™ 80 mg/mL Autoinjector <input type="checkbox"/> TALTZ™ 80 mg/mL Prefilled Syringe	<input type="checkbox"/> Injection: 160 mg (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks. <input type="checkbox"/> Other: _____	QTY: _____	_____
<input type="checkbox"/> OTHER MEDICATION: _____			

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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