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

☐ **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.