986 PHARMACY SPECIALTY

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DERMATOLOGY ENROLLMENT FORM

PATIENT INFORMATION

Name *(First, Last):* _____ ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **State:** __ __ **Zip Code:** __ __ __ __ __

Phone: (__ __ __) __ __ __ - __ __ __ __ **Date of Birth** (mm/dd/yyyy) : __ __ /__ __ /__ __ __ __ **Social Security #**__ __ __ - __ __ - __ __ __ __

PLEASE FAX COPY OF INSURANCE CARD (Front & Back)

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **COSENTYX**	☐ **150 mg/mL**	☐ **Induction Dose: Inject 300 mg SC x1 on wk 0, 1, 2, 3, 4, then every 4 wks** ☐ **Maintenance Dose: Inject 300 mg SC every 4 wks**		
☐ **DUPIXENT**	☐ **300 mg PFS 2x2mL**	☐ **Induction Dose: Inject 600 mg SC x1 on day 1 then every 2 wks starting day 15** ☐ **Maintenance Dose: Inject 300 mg SC every 2 wks**		
☐ **ENBREL**	☐ **50 mg/mL SureClick** ☐ **50 mg/mL Prefilled Syringe** ☐ **25 mg/0.5 mL Prefilled Syringe** ☐ **25 mg vial**	☐ **Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3-4 days apart) for 3 months, then start maintenance dose. (NO REFILLS)** ☐ **Maintenance Dose: Inject 50 mg Pen/PFS SC ONCE a week.** ☐ **Other:**		
☐ **HUMIRA**	☐ **Psoriasis Starter Package** ☐ **40 mg/0.8 mL Pen** ☐ **40 mg/0.8 mL Prefilled Syringe** ☐ **Other:** _____	☐ **Psoriasis Induction Dose: Inject two 40 mg pens/syringes SC on day 1, then pen/syringe on day 8, then one 40 mg pen/syringe every other week. (NO Refills)** ☐ **Maintenance Dose: Inject one 40 mg pen/syringe SC every other week.** ☐ **Other:**		
☐ **ILUMYA**	☐ **100MG mL syringe**	☐ **100 mg at Weeks 0, 4, and every twelve weeks thereafter**		
☐ **OTEZLA**	☐ **Titration Kit** ☐ **30MG**	☐ **Induction:Take as directed per package instructions** ☐ **Maintenance Dose:Take 1 tablet PO twice daily**		
☐ **SIMPONI**	☐ **50mg/0.5ml**	☐ **Inject 50 mg subcut once a month**		
☐ **STELARA**	☐ **45 mg/0.5 mL /1 syringe (weight < 100 kg)** ☐ **90 mg/ mL /1 syringe (weight > 100 kg)**	☐ **Induction Dose: Inject 45 mg SC x1 on wk 0, 4, then every 12 wks** ☐ **Maintenance Dose: Inject 45 mg SC every 12 wks** ☐ **Induction Dose: Inject 90 mg SC x1 on wk 0, 4, then every 12 wks** ☐ **Maintenance Dose: Inject 90 mg SC every 12 wks**		
☐ **SKYRIZI**	☐ **75 MG PFS 2X0.83ML KIT**	☐ **150 mg (two 75 mg injections) administered by subcutaneous injection at Week 0, Week 4 and every 12 weeks thereafter**		
☐ **SILIQ**	☐ **210 mg/1.5mL**	☐ **Induction Dose: Inject 210 mg SC x1 on wk 0, 1, 2, then every 2 wks** ☐ **Maintenance Dose: Inject 210 mg SC every 2 wks**		

PRIMARY DIAGNOSIS/ ICD-10-CM

☐ L40.0 (Psoriasis vulgaris) ☐ L40.52 (Psoriatic arthritis mutilans)

☐ L40.9 (Psoriasis, unspecified) ☐ L40.53 (Psoriatic spondylitis)

☐ L20.9 (Atopic Dermatitis)

BSA Affected _____

AFFECTED AREA(S) (For PsO ONLY): Hands Arms Nails Trunk Feet Legs Scalp Groin Other

PREVIOUS/CURRENT TREATMENT:

Total # of Dangerous Drugs Prescribed _____

PRESCRIBER'S INFORMATION

Prescriber Name *(First, Last):* _____ **NPI #:** __ __ __ __ __ __ __ __ __ __

Address: _____ **DEA #:** __ __ __ __ __ __ __ __ __

City: _____ **State:** __ __ **Zip Code:** __ __ __ __ __

Phone: (__ __ __) __ __ __ - __ __ __ __ **Fax:** (__ __ __) __ __ __ - __ __ __ __ **Contact Name:** _____

Physician Signature: _____ **Date:** ____ / ____ / ____

I authorize 986 Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process