



VITAL CARE RX

Tailored Therapy, Trusted Care

Dermatology Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)

Please fax copy of patient's insurance card including both sides

Name: _____

DOB: _____ Gender: M / F Height: _____ Wt: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Last 4 digits SS#: _____ Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State Lic. #: _____ NPI: _____

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact: _____

Phone: _____ Email: _____

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Diagnosis: ☐ L40.8 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa ☐ Other: _____

Severity of Psoriasis: ☐ Mild (up to 3 % BSA) ☐ Moderate (3 – 10% BSA) ☐ Severe (>10% BSA) BSA % : _____

Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other _____

Prior Failed Meds: ☐ Methotrexate Length of Treatment _____ Reason for Discontinuing _____

☐ PUVA/UVB Length of Treatment _____ Reason for Discontinuing _____

☐ Topicals Length of Treatment _____ List Specific Meds _____

☐ Other Length of Treatment _____ List Specific Meds _____

TB/PPD Test given? ☐ Yes ☐ No Results _____ Date _____ Allergies _____

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
Cosentyx® <input type="checkbox"/> 150mg Sensoready Pen <input type="checkbox"/> 150mg Prefilled Syringe	Initial Dose: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150 mg SC week 0,1,2,3,4	28 day supply	0
	Maintenance Dose: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC every 4 weeks	28 day supply	
Dupixent® <input type="checkbox"/> 300 mg Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 600 mg SC on day 1	1 starter kit	0
	<input type="checkbox"/> Maintenance: Inject 300 mg SC on day 15 and every 2 weeks thereafter	28 day supply	
Enbrel® <input type="checkbox"/> 50 mg Sureclick Autoinjector <input type="checkbox"/> 50 mg Prefilled Syringe <input type="checkbox"/> 25 mg Prefilled Syringe <input type="checkbox"/> 25 mg Vials	<input type="checkbox"/> Inject SC twice a week 72 - 96 hours apart <input type="checkbox"/> Inject SC once a week <input type="checkbox"/> Inject _____ mg (0.8mg/kg X _____ kg SC every week (≤ 63 kg) <input type="checkbox"/> Other:	28 day supply	
Humira® <input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Prefilled Syringe <input type="checkbox"/> Psoriasis Starter Kit CF <input type="checkbox"/> 40 mg CF Pen <input type="checkbox"/> 40 mg CF Prefilled syringe	<input type="checkbox"/> Initial Dose: Inject 80 mg SC on day 1, 40 mg on day 8, then maintenance dose every other week thereafter	1 starter kit	
	<input type="checkbox"/> Maintenance Dose: Inject 40 mg SC every other week	28 day supply	
Humira® HS <input type="checkbox"/> HS Starter Kit <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Prefilled Syringe <input type="checkbox"/> HS Starter Kit CF <input type="checkbox"/> 40 mg CF Pen <input type="checkbox"/> 40 mg CF Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 160 mg SC on day 1, 80mg on day 15, then 40mg every week beginning on day 29	1 starter kit	
	<input type="checkbox"/> Maintenance Dose: (At week 4) Inject 40mg SQ weekly	28 day supply	
Otezla® <input type="checkbox"/> Starter Pack <input type="checkbox"/> 30 mg tab	<input type="checkbox"/> Titrate as directed on package <input type="checkbox"/> Take 1 tablet by mouth twice daily	1 starter pack	0
		30 day supply	
Simponi® <input type="checkbox"/> 50 mg SmartJect <input type="checkbox"/> 50 mg Prefilled Syringe	<input type="checkbox"/> Inject 50 mg SC once a month as directed	28 day supply	
Stelara® <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe	<input type="checkbox"/> (< 220 lbs) Inject 45 mg on day 0 then week 4, followed by 45 mg dose every 12 weeks <input type="checkbox"/> (> 220 lbs) Inject 90 mg on day 0 then week 4, followed by 90 mg dose every 12 weeks	28 day supply	
Taltz® <input type="checkbox"/> 80 mg Autoinjector Pen <input type="checkbox"/> 80 mg Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 160 mg SC at week 0 then 80 mg at weeks 2,4,6,8,10 and 12	28 day supply	2
	<input type="checkbox"/> Maintenance Dose: Inject 80 mg SC every 4 weeks	28 day supply	
Tremfya™ <input type="checkbox"/> 100 mg Prefilled Syringe	<input type="checkbox"/> Inject 100 mg SC at week 0, week 4, and every 8 weeks thereafter	28 day supply	

Ship Medications To: ☐ Physician's Clinic ☐ Patient's Home

Injection Training Needed: ☐ Yes ☐ No

Prescriber Signature _____ Date _____ Brand Name Required? ☐ Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.