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: 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®	☐ 150mg Sensoready Pen ☐ 150mg Prefilled Syringe	Initial Dose: Inject ☐ 300mg or ☐ 150 mg SC week 0,1,2,3,4	28 day supply	0
		Maintenance Dose: Inject ☐ 300mg or ☐ 150mg SC every 4 weeks	28 day supply	
Cimzia®	☐ 200mg Starter Kit ☐ 200mg PFS Kit ☐ 200mg Vial Kit	☐ Initial Dose: Inject 400 mg SC at weeks 0, 2, & 4		
		☐ Maintenance: Inject 400 mg SC Q2wks ☐ Maintenance: Inject 200 mg SC Q2wks		
Dupixent®	☐ 200 mg Prefilled Syringe	☐ Initial Dose: Inject 400 mg SC on day 1 ☐ Maintenance: Inject 200 mg SC on day 15 and every 2 weeks thereafter.	1 starter kit	0
	☐ 300 mg Prefilled Syringe	☐ Initial Dose: Inject 600 mg SC on day 1 ☐ Maintenance: Inject 300 mg SC on day 15 and every 2 weeks thereafter	28 day supply	
Enbrel®	☐ 50 mg Sureclick Autoinjector ☐ 50 mg PFS ☐ 50 mg mini ☐ 25 mg PFS ☐ 25 mg Vials	☐ Inject SC twice a week 72 - 96 hours apart ☐ Inject SC once a week ☐ Inject ____ mg (0.8mg/kg X _____kg SC every week (≤ 63 kg) ☐ Other:	28 day supply	
Humira®	☐ Psoriasis Starter Kit ☐ 40 mg Pen ☐ 40 mg PFS ☐ Psoriasis Starter Kit CF ☐ 40 mg CF Pen ☐ 40 mg CF PFS	☐ Initial Dose: Inject 80 mg SC on day 1, 40 mg on day 8, then maintenance dose every other week thereafter	1 starter kit	
		☐ Maintenance Dose: Inject 40 mg SC every other week	28 day supply	
Humira® HS	☐ HS Starter Kit ☐ 40 mg Pen ☐ 40 mg PFS ☐ HS Starter Kit CF ☐ 40 mg CF Pen ☐ 40 mg CF PFS	☐ Initial Dose: Inject 160 mg SC on day 1, 80mg on day 15, then 40mg every week beginning on day 29	1 starter kit	
		☐ Maintenance Dose: (At week 4) Inject 40mg SQ weekly	28 day supply	
Ilumya™	☐ 100 mg/mL PFS	☐ Initial Dose: Inject 100 mg SC at week 0 & 4	2	0
		☐ Maintenance: Inject 100 mg SC Q12wks	1	
Otezla®	☐ Starter Pack ☐ 30 mg tab	☐ Titrate as directed on package ☐ Take 1 tablet by mouth twice daily	1 starter pack 30 day supply	0
Simponi®	☐ 50 mg SmartJect ☐ 50 mg PFS	☐ Inject 50 mg SC once a month as directed	28 day supply	
Stelara®	☐ 45 mg Prefilled Syringe ☐ 90 mg Prefilled Syringe	☐ (< 220 lbs) Inject 45 mg on day 0 then week 4, followed by 45 mg dose every 12 weeks ☐ (> 220 lbs) Inject 90 mg on day 0 then week 4, followed by 90 mg dose every 12 weeks	28 day supply	
Skyrizi®	☐ 75 mg 2 PFS Kit	☐ Initial Dose: Inject 150 mg SQ on week 0 & 4	4	0
		☐ Maintenance: Inject 150 mg SQ Q12wk	1	1
Taltz®	☐ 80 mg Autoinjector Pen ☐ 80 mg Prefilled Syringe	☐ 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
		☐ Maintenance Dose: Inject 80 mg SC every 4 weeks	28 day supply	
Tremfya™	☐ 100 mg Prefilled Syringe	☐ 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.