vitalcare SPECIALTY

VITAL CARE RX
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
☐ L20.9 Atopic Dermatitis ☐ Other:_____
Severity of Condition: ☐ 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 Maintenance Dose: Inject ☐ 300mg or ☐ 150mg SC every 4 weeks	28 day supply 28 day supply	0
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		
Cibinqo®	☐ 50 mg tablets ☐ 100 mg tablets ☐ 200 mg tablets	☐ Take 1 tablet by mouth once daily.	30 day supply	
Dupixent®	☐ 200mg/1.14mL Prefilled Pen ☐ 200mg/1.14mL Prefilled Syringe ☐ 300mg/2mL Prefilled Pen ☐ 300mg/2mL Prefilled Syringe	Adults and pediatric ≥ 60kg: ☐ 600 mg (two 300 mg injections) followed by 300 mg Q2W Pediatric Patients < 60kg: Body Weight / Initial Dose / Subsequent Doses ☐ 5 to less than 15kg — 200 mg (one 200mg injection) — 200 mg Q4wks ☐ 15 to less than 30 kg <6yr — 300 mg (one 300 mg injections) — 300 mg Q4wks ☐ 15 to less than 30 kg ≥6yr — 600 mg (two 300 mg injections) — 300 mg Q4wks ☐ 30 to less than 60 kg — 400 mg (two 200 mg injections) — 200 mg Q2wks	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 ☐ Maintenance Dose: Inject 40 mg SC every other week	1 starter kit 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 ☐ 80 mg CF Pen	☐ Initial Dose: Inject 160 mg SC on day 1, 80mg on day 15, then 40mg every week beginning on day 29 ☐ Maintenance Dose: (At week 4) Inject 40mg SQ weekly ☐ Inject 80mg every other week	1 starter kit 28 day supply	
Olumiant®	☐ 2 mg tablet ☐ 4 mg tablet	☐ Take 1 tablet by mouth once daily	30 day supply	
Otezla®	☐ Titration Starter Pack ☐ 30 mg Tablets	☐ Initial Dose: Titrate as directed on package ☐ Maintenance Dose: Take 1 tablet by mouth twice daily	1 starter pack 30 day supply	0
Rinvoq™	☐ 15 mg ER tablet ☐ 30 mg ER tablet	☐ Take one (15mg) tablet PO once daily ☐ Take one (30mg) tablet PO once daily ☐ Other:	30 day supply	
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 ☐ 150 mg Pen ☐ 150 mg PFS	☐ Initial Dose: Inject 150 mg SC on week 0 & 4 ☐ Maintenance: Inject 150 mg SC Q12wk	1 1	0
Sotyktu®	☐ 6 mg Tablet	☐ Take 1 tablet by mouth once a day	30 day supply	
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 ☐ Maintenance Dose: Inject 80 mg SC every 4 weeks	28 day supply 28 day supply	2
Tremfya™	☐ 100 mg Prefilled Pen ☐ 100 mg Prefilled Syringe	☐ Initial Dose: Inject 100 mg SC at week 0 & 4 ☐ Maintenance: Inject 100 mg SC Q8wks	2 1	0
☐ Other				

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.