CITYDRUGS

1752 1st Avenue New York, NY 10128
Tel: 855-988-4500 / Fax: 212-988-4501
citydrugs.com

Dermatology Enrollment Form

Ship to: Office Patient Other ______________________________

PATIENT INFORMATION

(Complete the following or send Patient's demographic sheet)

Patient Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Alternate Phone: ______________________
SS #: ______________________
Date of Birth: __________ Gender __________

PRESCRIBER INFORMATION

Prescriber's Name: ______________________
State License #: __________ UPIN: __________
DEA #: __________ NPI #: __________
Group or Hospital: ______________________
Address: ______________________
City, State, Zip: ______________________
Phone: __________ Fax: __________
Contact Person:

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Phone: __________
Secondary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Phone: __________

STATEMENT OF MEDICAL NECESSITY

Diagnosis

L40.0 Psoriasis L40.59 Psoriatic Arthritis Other: __________

☐ Date of Diagnosis: __________ OR Years With Disease __________

Prior (FAILED) Medication

	Medication	*Reason for Discontinuation*
Biologics:	__________	__________
Methotrexate	N/A	__________
Oral Meds:	__________	__________
PUVA	N/A	__________
UVB	N/A	__________
Topicals:	__________	__________
Other:	__________	__________

Medical Assessment (Within Last 12 Months)

☐ Psoriasis Severity: Moderate Moderate to Severe Severe

☐ Psoriasis Type: Plaque Other (please specify): __________

Patient Evaluation:

☐ Has Patient been diagnosed with Heart Failure? Yes No
☐ Has patient been diagnosed with Lymphoma? Yes No
☐ Does patient have serious/active infection? Yes No
☐ Has TB test been performed? Yes No
If yes, results: __________ Comments: __________
☐ Has Hepatitis B been ruled out or treatment been initiated? Yes No
If No, has treatment been initiated? Yes No

☐ Does patient have a latex allergy? Yes No
☐ Is patient's platelet count >52,000 cells/uL? Yes No
☐ Patient Weight: ______kg/lbs
☐ Allergies: Yes NKDA

PRESCRIPTION INFORMATION *(Please choose induction and maintenance dose)*

MEDICATION	STRENGTH	DIRECTIONS
HUMIRA®	40 mg/0.4 mL (0.4 mL) Citrate-free Pen-injector/Prefilled Syringe	Psoriasis Induction Dose: Inject two 40mg pens/syringes SC on day 1, then one 40mg pen/syringe on day 8, then one 40mg pen every other week. Maintenance Dose: 40 mg every other week beginning 1 week after initial dose Hidradenitis Suppurativa (HS) is 160mg (4 pens) on Day 1, followed by 80 mg (2 pens) two weeks later (Day 15). Maintenance Dose: 40 mg weekly. (Start at day 29)
ENBREL®	50mg/ml Sureclick Autoinjector 50mg/ml Prefilled Syringe 25mg/0.5ml Prefilled Syringe 25mg Vial	Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing Psoriasis Maintenance Dose: Inject 50mg SC ONCE a week. Psoriatic Arthritis Dose: Inject 50mg SC ONCE a week. Other: __________
OTEZLA®	28 day starter pack 30mg Tablets	As directed As directed
COSENTYX®	150mg/ml Pen 150mg/ml Pre-filled Syringe 150mg, lyophilized powder in a single-use vial for reconstitution (for healthcare professional use only)	Plaque Psoriasis 300mg SubQ Weeks 0, 1, 2, 3, and 4 followed by 300mg every 4 weeks. Each 300mg dosage is given as 2 SubQ injections of 150mg. For some patients a dose 3 of 150mg may be acceptable.
SIMPONI®	50mg/0.5ml SmartJect™ Autoinjector 50mg/0.5ml Prefilled Syringe	Psoriatic Arthritis Dose: Inject 50 mg (0.5ml) subcutaneously once a month Other: __________
STELARA®	45mg/0.5ml prefilled syringe and 90mg/1ml 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 (two 45mg vials) SC initially and 4 weeks later, followed by 90mg every 12 weeks.
TALTZ®	80 mg/ ml single dose prefilled autoinjector	Administer by subcutaneous injection Recommended dose is 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.
SKYRIZI ™	Two consecutive injections (75 mg each)	Two consecutive injections (75 mg each) for a total dose of 150 mg at weeks 0, 4, and then every 12 weeks thereafter.
ILUMIA ™	100 mg	100 mg at weeks 0, 4, and then every 12 weeks thereafter.
TREMFYA ™	100 mg	100 mg at weeks 0, 4, and then every 8 weeks thereafter.
SILIQ ™	210 mg	210 mg at weeks 0, 1, and 2, followed by 210 mg once every 2 weeks.

Other Medications:
Current Medication List __________
Dosage __________
Strength __________

Any known allergies? Yes No

By signing this form Physician authorized CityDrugs Pharmacy to act as his or her agent in the initiation and execution of patient's insurance Prior Authorization process and agrees to provide CityDrugs Pharmacy all lab results to assist with identification of treatment duration and or futility. The Physician understands that since the patient is on continuous therapy and will inform the Pharmacy should the therapy be discontinued.

Physician's Signature: ☐ DAW (Dispense as Written) Date_____/_____/_____

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to City Drugs Specialty Pharmacy using the contact .information provided on this cover sheet