Dermatology Enrollment Form (A-E)

www.pyramidspharmacy.com All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: ______________________ Birthdate: __________ Sex: Male Female Height: ______ Weight: ______ ❑lbs. ❑kg.

Soc. Sec. #: ______________ Preferred Phone: ______________ Known Allergies: ______________________

Address: ________________________________ City: ______________ State: ______ Zip: ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: ________________________ Plan Phone: ______________________

ID #: ______________ Group #: ______________ RxBIN: ______________ RxPCN: ______________

2: Prescriber Information

Prescriber Name: ________________________ DEA#: __________ NPI#: __________ Tax ID#: __________

Address: ________________________ Phone: (_____) ______-______ Fax: (_____) ______-______

City: ______________ State: ______ Zip: ______ Key Contact: ______________ Phone: (_____) ______-______

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):
- ❑ **L20.9 Atopic Dermatitis**
- ❑ **L40.9 Psoriasis Vulgaris**
- ❑ **L40.50 Arthropathic Psoriasis**
- ❑ **L40.59 Psoriatic Arthritis**
- ❑ **L40.8 Other Psoriasis**
- ❑ **L40.9 Psoriasis, Unspecified**
- ❑ **L73.2 Hidradenitis Suppurativa**
- ❑ **Other:** ______________________

% BSA affected: ______________

Scoring Tool Name: ______________

TB Test Completed: ❑ Yes ❑ No
Date of Negative Test: __________

If history of latent TB, has patient received treatment? ❑ Yes ❑ No

Hep B Screening:
❑ Positive ❑ Negative ❑ N/A
Date of Hep B Test: ______________

Does the patient have an active infection?
❑ Yes ❑ No

Concomitant Medications: ______________________

Please list previously tried and failed therapies & reason for discontinuing:
- ❑ Biologics: ______________
- ❑ Calcineurin Inhibitors: ______________
- ❑ Corticosteroids: ______________
- ❑ Leflunomide: ______________
- ❑ Methotrexate: ______________
- ❑ Hydroxyurea: ______________
- ❑ Sulfasalazine: ______________
- ❑ Phototherapy: ______________
- ❑ Topicals: ______________
- ❑ Other: ______________

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Cimzia®	❑ Cimzia Starter Kit	**Initial Dose (PsA or Psoriasis patients ≤90 kg)**: ❑ Inject 400 mg (two 200 mg injections) subQ at Weeks 0, 2, and 4, then maintenance dose.	1 kit (six 200 mg Prefilled Syringes)	0
	❑ 200 mg Vial ❑ 200 mg Prefilled Syringe	**Maintenance Dose**: ❑ *PsA or Psoriasis patients ≤90 kg*: Inject 200 mg subQ every 2 weeks. ❑ *Alternative PsA*: Inject 400 mg subQ (two 200 mg injections) every 4 weeks. ❑ *Psoriasis*: Inject 400 mg subQ (two 200 mg injections) every 2 weeks.		
❑ Cosentyx®	❑ 150 mg Sensoready Pen ❑ 150 mg Prefilled Syringe	*Psoriatic Arthritis* ❑ **Initial Dose**: Inject 150 mg subQ at Weeks 0, 1, 2, 3, and 4, then maintenance dose ❑ **Maintenance Dose**: Inject 150 mg subQ every 4 weeks.		
		Plaque Psoriasis ❑ **Initial Dose**: Inject 300 mg (two 150 mg injections) subQ at Weeks 0, 1, 2, 3, and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject 300 mg (two 150 mg injections) subQ every 4 weeks. *Cosentyx Service Request Form available at www.pyramidspharmacy.com*		
❑ Dupixent®	❑ 300 mg Prefilled Syringe	❑ **Initial Dose**: Inject 600 mg (two 300 mg injections) subQ on Day 1, then maintenance dose starting on Day 15. ❑ **Maintenance Dose**: Inject 300 mg subQ every other week. *Dupixent MyWay Enrollment Form available at www.pyramidspharmacy.com*		
❑ Enbrel®	❑ 25 mg Vial ❑ 25 mg Prefilled Syringe ❑ 50 mg Prefilled Syringe ❑ 50 mg Sureclick Autoinjector ❑ 50 mg/mL Mini Prefilled Cartridge for use with the AutoTouch reusable autoinjector only	*Psoriatic Arthritis* ❑ Inject 50 mg subQ every week. ❑ Inject 25 mg subQ twice a week (72-96 hours apart).		
		Plaque Psoriasis ❑ **Initial Dose**: Inject 50 mg subQ twice weekly (72-96 hours apart) for 3 months then maintenance dose. ❑ **Maintenance Dose**: Inject 50 mg subQ every week.		

Deliver to: ❑Patient ❑Office ❑Other: ______________ Date: __________ Needs by Date: __________

*Prescriber Authorization: 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(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms 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 the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: ______________________ Date: __________

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Dermatology Enrollment Form (F-O)

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500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: ______________________ Birthdate: __________ Sex: Male Female Height: ______ Weight: ______ ❑lbs. ❑kg.

Soc. Sec. #: ______________ Preferred Phone: ______________ Known Allergies: ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: ______________________ Plan Phone: ______________

ID #: ______________ Group #: ______________ RxBIN: ______________ RxPCN: ______________

2: Prescriber Information

Prescriber Name: ______________________ DEA#: __________ NPI#: __________ Tax ID#: __________

Address: ______________________ Phone: (_____) ______- ______ Fax: (_____) ______- ______

City: ______________ State: ______ Zip: ______ Key Contact: ______________ Phone: (_____) ______- ______

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):
- ❑ **L20.9 Atopic Dermatitis**
- ❑ **L40.9 Psoriasis Vulgaris**
- ❑ **L40.50 Arthropathic Psoriasis**
- ❑ **L40.59 Psoriatic Arthritis**
- ❑ **L40.8 Other Psoriasis**
- ❑ **L40.9 Psoriasis, Unspecified**
- ❑ **L73.2 Hidradenitis Suppurativa**
- ❑ **Other:** ______________

% BSA affected: ______________

Scoring Tool Name: ______________

TB Test Completed: ❑ Yes ❑ No
Date of Negative Test: __________

If history of latent TB, has patient received treatment? ❑ Yes ❑ No

Hep B Screening:
❑ Positive ❑ Negative ❑ N/A
Date of Hep B Test: ______________

Does the patient have an active infection?
❑ Yes ❑ No

Concomitant Medications: ______________

Please list previously tried and failed therapies & reason for discontinuing:
- ❑ Biologics: ______________
- ❑ Calcineurin Inhibitors: ______________
- ❑ Corticosteroids: ______________
- ❑ Leflunomide: ______________
- ❑ Methotrexate: ______________
- ❑ Hydroxyurea: ______________
- ❑ Sulfasalazine: ______________
- ❑ Phototherapy: ______________
- ❑ Topicals: ______________
- ❑ Other: ______________

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Humira®	❑ Psoriasis Starter Kit ❑ HS Starter Kit	❑ **Psoriasis Initial Dose**: Inject 80 mg subQ on Day 1, then 40 mg on Day 8, then 40 mg on Day 22, followed by maintenance dose. ❑ **HS Initial Dose**: Inject 160 mg (two 80 mg injections) subQ on Day 1, then 80 mg on Day 15, then maintenance dose starting Day 29. ❑ **HS *Alternative* Initial Dose**: Inject 80 mg subQ on Day 1, followed by 80 mg on Day 2, then 80 mg on Day 15, then maintenance dose starting Day 29.	1 Kit	0
	❑ 40 mg Pen ❑ 40 mg Pen (citrate-free) ❑ 40 mg PFS ❑ 40 mg PFS (citrate-free)	❑ **Psoriasis Maintenance Dose**: Inject 40 mg subQ every *other* week. ❑ **HS Maintenance Dose**: Inject 40 mg subQ every week. ❑ **Psoriatic Arthritis Dose**: Inject 40 mg subQ every *other* week.		
❑ Ilumya™	❑ 100 mg/mL Prefilled Syringe	❑ **Initial Dose**: Inject 100 mg subQ at Weeks 0 and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject 100 mg subQ every 12 weeks.		
❑ Odomzo®	❑ 200 mg capsule	❑ Take one capsule (200 mg) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal.		
❑ Orencia® *(PsA only)*	❑ 250 mg Vial *Patient Dosing Wt:* __________*kg*	❑ Infuse _________ mg IV at Weeks 0, 2, and 4, then every 4 weeks thereafter.		
	❑ 125 mg Prefilled Syringe ❑ 125 mg Autoinjector	❑ Inject 125 mg subQ every week.		
❑ Otezla®	❑ Titration Starter Pack	❑ **Initial Dose**: Take as directed on starter pack.	1 Starter Pack	0
	❑ 30 mg tablet	❑ **Maintenance Dose**: Take one tablet (30 mg) by mouth twice daily. ❑ Other: ______________ *Otezla START Form available at www.pyramidspharmacy.com*		

Deliver to: ❑Patient ❑Office ❑Other: ______________ Date: ______________ Needs by Date: ______________

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Dermatology Enrollment Form (P-S)

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500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: ______ Birthdate: ______ Sex: Male Female Height: ______ Weight: ______ ❑lbs. ❑kg.

Soc. Sec. #: ______ Preferred Phone: ______ Known Allergies: ______

Address: ______ City: ______ State: ______ Zip: ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: ______ Plan Phone: ______

ID #: ______ Group #: ______ RxBIN: ______ RxPCN: ______

2: Prescriber Information

Prescriber Name: ______ DEA#: ______ NPI#: ______ Tax ID#: ______

Address: ______ Phone: (____) ______ - ______ Fax: (____) ______ - ______

City: ______ State: ______ Zip: ______ Key Contact: ______ Phone: (____) ______ - ______

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

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- ❑ **L20.9 Atopic Dermatitis**
- ❑ **L40.9 Psoriasis Vulgaris**
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- ❑ **L40.59 Psoriatic Arthritis**
- ❑ **L40.8 Other Psoriasis**
- ❑ **L40.9 Psoriasis, Unspecified**
- ❑ **L73.2 Hidradenitis Suppurativa**
- ❑ **Other:** ______

% BSA affected: ______

Scoring Tool Name: ______

TB Test Completed: ❑ Yes ❑ No
Date of Negative Test: ______

If history of latent TB, has patient received treatment? ❑ Yes ❑ No

Hep B Screening:
❑ Positive ❑ Negative ❑ N/A
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Does the patient have an active infection?
❑ Yes ❑ No

Concomitant Medications: ______

Please list previously tried and failed therapies & reason for discontinuing:
- ❑ Biologics: ______
- ❑ Calcineurin Inhibitors: ______
- ❑ Corticosteroids: ______
- ❑ Leflunomide: ______
- ❑ Methotrexate: ______
- ❑ Hydroxyurea: ______
- ❑ Sulfasalazine: ______
- ❑ Phototherapy: ______
- ❑ Topicals: ______
- ❑ Other: ______

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Remicade®	❑ 100 mg Vial *Patient Dosing Wt:* ______*kg*	❑ **Initial Dose**: Infuse ______ mg (5 mg/kg) IV at Weeks 0, 2, and 6, then maintenance dose. ❑ **Maintenance Dose**: Infuse ______ mg (5 mg/kg) IV every 8 weeks.		
❑ Renflexis™	❑ 100 mg Vial *Patient Dosing Wt:* ______*kg*	❑ **Initial Dose**: Infuse ______ mg (5 mg/kg) IV at Weeks 0, 2, and 6, then maintenance dose. ❑ **Maintenance Dose**: Infuse ______ mg (5 mg/kg) IV every 8 weeks.		
❑ Siliq™	❑ 210 mg/1.5 mL Prefilled Syringe	❑ **Initial Dose**: Inject 210 mg subQ at Weeks 0, 1 and 2, followed by maintenance dose. ❑ **Maintenance Dose**: Inject 210 mg subQ every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: https://siliqrems.com/SiliqUI/home.u		
❑ Simponi® *(PsA only)*	❑ 50 mg Autoinjector ❑ 50 mg Prefilled Syringe	❑ Inject 50 mg subQ once a month.		
❑ Simponi Aria® *(PsA only)*	❑ 50 mg/4 mL Vial *Patient Dosing Wt:* ______*kg*	❑ **Initial Dose**: Infuse ______ mg (2 mg/kg) IV at Weeks 0, 4, then maintenance dose. ❑ **Maintenance Dose**: Infuse ______ mg (2 mg/kg) IV every 8 weeks.		
❑ Stelara®	❑ 45 mg Prefilled Syringe **(PsA or Psoriasis patients ≤ 100 kg)** ❑ 90 mg Prefilled Syringe **(Psoriasis patients > 100 kg)**	❑ **Initial Dose**: Inject one syringe subQ at Weeks 0 and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject one syringe subQ every 12 weeks.		

Deliver to: ❑Patient ❑Office ❑Other: ______ Date: ______ Needs by Date: ______

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Dermatology Enrollment Form (T-Z)

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1: Patient Information

Patient Name: ______________ Birthdate: ________ Sex: Male Female Height: ______ Weight: ______ ❑lbs. ❑kg.

Soc. Sec. #: ____________ Preferred Phone: ____________ Known Allergies: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: ____________ Plan Phone: ____________

ID #: ____________ Group #: ____________ RxBIN: ____________ RxPCN: ____________

2: Prescriber Information

Prescriber Name: ____________ DEA#: ________ NPI#: ________ Tax ID#: ________

Address: ____________ Phone: (____) ____-____ Fax: (____) ____-____

City: ____________ State: ______ Zip: ______ Key Contact: ____________ Phone: (____) ____-____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):
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- ❑ **L40.59 Psoriatic Arthritis**
- ❑ **L40.8 Other Psoriasis**
- ❑ **L40.9 Psoriasis, Unspecified**
- ❑ **L73.2 Hidradenitis Suppurativa**
- ❑ **Other:** ____________

% BSA affected: ____________

Scoring Tool Name: ____________

TB Test Completed: ❑ Yes ❑ No
Date of Negative Test: ____________

If history of latent TB, has patient received treatment? ❑ Yes ❑ No

Hep B Screening:
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Does the patient have an active infection?
❑ Yes ❑ No

Concomitant Medications: ____________

Please list previously tried and failed therapies & reason for discontinuing:
- ❑ Biologics: ____________
- ❑ Calcineurin Inhibitors: ____________
- ❑ Corticosteroids: ____________
- ❑ Leflunomide: ____________
- ❑ Methotrexate: ____________
- ❑ Hydroxyurea: ____________
- ❑ Sulfasalazine: ____________
- ❑ Phototherapy: ____________
- ❑ Topicals: ____________
- ❑ Other: ____________

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Taltz®	❑ 80 mg Autoinjector ❑ 80 mg Prefilled Syringe	*Psoriatic Arthritis* ❑ **Initial Dose**: Inject 160 mg (two 80 mg injections) subQ on Day 1, then maintenance dose starting Day 29. ❑ **Maintenance Dose**: Inject 80 mg subQ every 4 weeks. *Plaque Psoriasis* ❑ **Initial Dose**: Inject 160 mg (two 80 mg injections) subQ at Week 0, then 80 mg at Weeks 2, 4, 6, 8, 10, 12, then maintenance dose. ❑ **Maintenance Dose**: Inject 80 mg subQ every 4 weeks.		
❑ Tremfya™	❑ 100 mg Prefilled Syringe	❑ **Initial Dose**: Inject 100 mg subQ at Weeks 0 and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject 100 mg subQ every 8 weeks.		
❑ Xeljanz® *(PsA only)*	❑ 5 mg tablet	❑ Take one tablet by mouth twice daily.		
❑ Xeljanz® XR *(PsA only)*	❑ 11 mg tablet	❑ Take one tablet by mouth once daily.		

Deliver to: ❑Patient ❑Office ❑Other: ____________ Date: ____________ Needs by Date: ____________

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