Dermatology Enrollment Form (F-O)

PYRAMIDS SPECIALTY PHARMACY

www.pyramidspharmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I 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: _____

*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: _____