Dermatology Enrollment Form (P-S)

PYRAMIDS SPECIALTY PHARMACY

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

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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):
- ❑ **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
❑ 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: ____________

*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: ____________

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.