Dermatology Enrollment Form (A-E)

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
❑ 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: _____

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.