Parkway
SPECIALTY PHARMACY

Dermatology Enrollment Form A-H

3502 U.S. Highway 9. Howell. N.J. 07731 | www.**parkwaysp**.com | Email: intake@parkwaysp.com | Phone: 1-866-355-7797 | Fax: 1-888-551-6289

PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Email:
SS #:	Primary Language:		Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: **Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other**

Drug	Dose	Direction & Quantities	Refills
O **Botox**	O 100 unit vial O 200 unit vial	O Frequency: ____________________ (minimum is 12 weeks, unless otherwise specified) O Location for injection (specify site(s)): ____ O Number of units per site: ____	
O **Cimzia**	O Pre-filled Syringe O Vials	O Inject 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week. For some patients (with body weight <90kg), a dose of 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4, followed by 200 mg every other week.	
O Cosentyx	O Sensoready Pen O Pre-filled Syringe	O INITIAL: Inject 300 mg SC on week 0, 1, 2, 3, and 4 (Qty: 10) O MAINTENANCE: Inject 300 mg SC every 4 weeks (Qty: 2)	
O Dupixent	O Pre-filled Syringe O Pen	O INITIAL: Inject 600 mg (two 300 mg injections in different sites) SC on day 1 (Qty: 2) O MAINTENANCE: Inject 300 mg SC every **other** week starting at day 15 (Qty: 2)	
O Enbrel	O SureClick® Pen O Mini™ with AutoTouch™ O Pre-filled Syringe O 25 mg O 50 mg O Vials 25 mg	O INITIAL: Inject 50 mg SC twice weekly (72-96 hours apart) for 3 months (Qty: 8 w/ 2 refills) O MAINTENANCE: Inject 50 mg SC weekly (Qty: 4)	
O Humira	O Psoriasis Starter Kit O Pen O Pre-filled Syringe	O INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (1 Kit) O MAINTENANCE: Inject 40 mg SQ every **other** week (Qty: 2)	
O Humira CF	O HS Starter Kit O Pen O Pre-filled Syringe	O INITIAL: Inject 160 mg SQ on day 1, then 80 mg on day 15 (1 Kit) O MAINTENANCE: Inject 40 mg SQ every week (Qty: 4)	

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

PREVIOUS THERAPIES:	O Cyclosporine	O Elidel	PHOTOTHERAPY
	O Methotrexate	O Eucrisa	O UVA /UVB
	O Soriatane	O Stelara	
	O Clobetasol	O Humira	O Other: ____________________
	O Hydrocortisone	O Enbrel	

O L20.9 Atopic Dermatitis (Moderate to Severe) O L40.0 Psoriasis Vulgaris (Plaque Psoriasis)

O Other: ______________________________ Date of Diagnosis: ____/____/______

Active TB is ruled out: O Yes O No Date: ____/____/______ Hep B ruled out/treated: O Yes O No Date: ____/____/______

Patient Height:____________________ in/cm Weight: ____________________ kg/lbs

Additional Clinical Information:

INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

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Faxed Prescriptions will only be accepted from a prescribing practitioner.