Dermatology Enrollment Form I-Z

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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
Ilumya™	O 100 mg Pre-filled syringe	O INITIAL: Inject 100 mg SC at week 0 and week 4 (Qty: 2) O MAINTENANCE: Inject 100 mg SC every 12 weeks (Qty: 1)	
Otezla®	O 28 Day Starter Pack O Maintenance	O Take as directed per package instructions. (Qty: 55) O Take 30 mg PO twice daily (Qty: 60) O Take 30 mg PO once daily (Qty: 30). **Renal Dosing** Continuation of Therapy: O Yes O No	
Siliq™	O Pre-filled Syringe	O INITIAL: Inject 210 mg SC on weeks 0 and 1 (Qty: 2) O MAINTENANCE: Inject 210mg SC every 2 weeks starting at week 2 (Qty: 2) O REMS	
Skyrizi™	O Pre-filled Syringe O Pen injector	O INITIAL: Inject 150 mg SC at week 0 and week 4 O MAINTENANCE: Inject 150 mg SC every 12 weeks thereafter	
Sotyktu®	O 6 mg tablet	O Take one tablet daily with or without food (Qty: 30)	
Stelara®	O 45 mg <100 kg O 90 mg >100kg O Vials 45 mg	O INITIAL: Inject SC on day 0 and day 28 (Qty: 2) O MAINTENANCE: Inject SC every 12 weeks (Qty: 1)	
Taltz®	O 80 mg/ml autoinjector O 80 mg/ml Pre-filled syringe	O INITIAL: inject 160mg SC at week 0, then begin induction dose 2 weeks later. (Qty: 3 pens/syringes) O INDUCTION DOSE: inject 80mg SC every two weeks (weeks 4 - 10). (Qty: 2 pens/syringes) O FINAL INDUCTION DOSE: inject 80mg SC at week 12. (Qty: 1 pen/syringe) O MAINTENANCE DOSE: inject 80 mg SC every 4 weeks (thereafter) (Qty: 1 pen/syringe)	
Tremfya™	O Pre-filled Syringe O One - Press Injector	O INITIAL: Inject 100 mg SC on week 0 and week 4 (Qty: 1) (Refill: 1) O MAINTENANCE: Inject 100 mg SC every 8 weeks (Qty: 1)	
Vtama Cream	O 1%	O Apply a thin layer to affected area once daily (Qty: 60gm)	
Zoryve Cream	O 0.3%	O Apply once daily to afected area (Qty: 60gm)	

MEDICAL INFORMATION

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

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

O L40.0 Psoriasis Vulgaris (Plaque Psoriasis) O L40.9: Psoriasis, unspecified. O L73.2 HS Date of Diagnosis: ____/____/_______

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

Allergies: 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

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Faxed Prescriptions will only be accepted from a prescribing practitioner.