RxReach
Your Connection to Better Health

Dermatology Enrollment Form

PATIENT INFORMAION

Please complete the following or send patient demographic sheet

Patient Name ____________________

Address ____________________

Address 2 ____________________

City, State, ZIP ____________________

Home Phone ____________ Alternate Phone ____________

DOB ________ Last Four of SS# ________ Gender ________

Language Preference: English Spanish Other ________

PRESCRIBER INFORMATION

Prescriber's Name ____________________

DEA ____________________

NPI ____________________

Group/ Hospital ____________________

Address ____________________

City, State, ZIP ____________________

Phone ____________ Fax ____________

Contact Person ____________ Phone ____________

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number ____________________

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

L40.0 Psoriasis vulgaris
L40.1 Generalized pustular psoriasis
L40.2 Acrodermatitis continua
L40.3 Pustulosis palmaris et plantaris
L40.4 Guttate psoriasis
L40.54 Psoriatic juvenile arthropathy
L40.59 Other psoriatic arthropathy
L73.2 Hidradenitis suppurativa
L40.8 Other psoriasis ____________________

Other Diagnosis: ICD-10 Code ________

Description ____________________

Date of Diagnosis ____________________

Has a TB test been performed? Yes No

Does the patient have an active infection? Yes No

Start Date ____________ **Review Date** ____________

Additional Information Therapy: New Reauthorization Restart

Weight ____________ kg/ lbs Height ____________ cm/ in

Allergies ____________________

Lab Data ____________________

Prior Therapies ____________________

Concomitant Medications ____________________

____

Additional Comments ____________________

Injection Training Required: Yes No

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
Cimzia®	☐ 200 mg/mL Prefilled Syringe Starter Kit ☐ 200 mg/mL Vial Kit ☐ 200 mg/mL Prefilled Syringe			
Cosentyx®	☐ 150 mg/mL Prefilled Pen ☐ 150 mg/mL Prefilled Syringe ☐ 150 mg/mL (300 mg dose) Prefilled Pen ☐ 150 mg/mL (300 mg dose) Prefilled Syringe			
Dupixent®	☐ 300 mg/2 mL Prefilled Syringe			
Enbrel®	☐ 50 mg/mL SureClick Autoinjector ☐ 25 mg/0.5 mL Prefilled Syringe ☐ Enbrel Mini® 50 mg/mL Cartridge ☐ 50 mg/mL Prefilled Syringe ☐ 25 mg Vial			
Humira®	☐ 40 mg/0.4 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.8 mL Pen ☐ 80 mg/0.8 mL & 40 mg/0.4 mL Pen PS/UV Starter Pack (citrate-free) ☐ 40 mg/0.4 mL Pen (citrate-free) ☐ 40 mg/0.8 mL Prefilled Syringe ☐ 80 mg/0.8 mL Pen CD/UC/HS Starter Pack (citrate-free) ☐ 40 mg/0.8 mL Pen PS/UV Starter Pack ☐ 40 mg/0.8 mL Pen CD/UC/HS Starter Pack			
Ilumya™	☐ 100 mg/mL Prefilled Syringe			
Inflectra®	☐ 100 mg Vial ☐ Starter Pack (28-day)			
Otezla®	☐ 30 mg Tablet ☐ Starter Pack (28-day) ☐ Starter Pack (2-week)			
Remicade®	☐ 100 mg Vial			
Renflexis®	☐ 100 mg Vial			
Siliq®	210 mg/1.5 mL Prefilled Syringe			
Simponi®	50 mg/0.5 mL Prefilled Syringe 50 mg/0.5 mL SmartJect Autoinjector			
Simponi Aria®	50 mg/4 mL Vial			
Stelara®	45 mg/0.5 mL Vial 90 mg/mL Prefilled Syringe 45 mg/0.5 mL Prefilled Syringe			
Taltz®	80 mg/mL Autoinjector 80 mg/mL Prefilled Syringe			
Tremfya®	100 mg/mL Prefilled Syringe			
Xeljanz®	5 mg Tablet			
☐ **Xeljanz XR®**	☐ 11 mg Extended-Release Tablet			
☐ Other ____________				

Ship 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

Prescriber's Signature ____________________ Date ____________

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