Dermatology Enrollment Form (A-N)

Phone: 602-971-6950 / 877-971-3001
Fax: 877-552-5698

VASCO SPECIALTY-INFUSION
An AleraCare Company AleraCare A Healthcare Solutions Company

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

Prescriber Information

Prescriber Name:	◯MD ◯DO ◯NP ◯PA	NPI:	
Office Contact:	Practice Name / Collaborating MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯M ◯F	Weight:	Height:	Diabetic: ◯Y ◯N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	◯ Psoriasis Vulgaris (L40.0) ◯ Other Psoriasis (L40.8) ◯Psoriasis unspecified (L40.9) ◯Psoriatic Arthritis (L40.5) ◯ Hidradenitis Suppurativa (L73.2) ◯Chronic Urticaria (L50.8)				
◯Atopic Dermatitis (L20.9)	◯ Basal cell carcinoma (C44.____)	TB/PDD Test Given? ◯Y ◯N	Date of Neg. Test: / /	HBV Positive? ◯Y ◯N	If yes, patient currently treated? ◯Y ◯N
Prior Treatment? ◯ Y ◯ N (Provide Information Below)	BSA affected (%):	Affected Areas: ◯Palms ◯Soles ◯Head ◯Neck ◯Genitalia ◯Other:			
Prior Therapy	Reason for Discontinuation of Therapy			Approx. Start Date	Approx. End Date
Comorbidities:	Concomitant Medications:			Allergies: ◯ NKDA ◯ Other:	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **CIMZIA®** ◯ PFS ◯ Vials	◯ 1 starter kit (6x200mg/mL)	◯ **Starter Dose:** Inject 400 mg SQ at weeks 0, 2 and 4	**No Refills**
	◯ 1 carton (2x200mg/mL) ◯ 2 cartons (4x200mg/mL)	**Maintenance Dose:** ◯ Inject 400mg SQ every 4 weeks ◯ Inject 200mg SQ every 2 weeks ◯ Inject 400mg SQ every other week *(plaque psoriasis only)* ◯ Inject 200mg SQ every other week	
◯ **COSENTYX®** ◯ PFS ◯ Sensoready® Pen	◯ 4 cartons (8x150mg/mL) ◯ 4 cartons (4x150mg/mL)	◯ **Starter Dose:** Inject 300 mg SQ at weeks 0, 1, 2, and 3 ◯ **Starter Dose:** Inject 150 mg SQ at weeks 0, 1, 2, and 3	**No Refills**
	◯ 1 carton (2x150mg/mL) ◯ 1 carton (1x150mg/mL)	◯ **Maintenance Dose:** Inject 300 mg SQ every 4 weeks beginning on Day 29 ◯ **Maintenance Dose:** Inject 150 mg SQ every 4 weeks beginning on Day 29	
◯ **DUPIXENT®** ◯ PFS (with needle shield)	◯ 1 carton (2x200mg/1.14mL) ◯ 1 carton (2x300mg/2mL)	**Starter Dose:** ◯ **Adolescents weighing less than 60kg:** Inject 400mg SQ at week 0. Begin maintenance dose at week 2 ◯ **Adolescents weighing ≥60kg and adults:** Inject 600mg SQ at week 0. Begin maintenance dose at week 2	**No Refills**
	◯ 1 carton (2x200mg/1.14mL) ◯ 1 carton (2x300mg/2mL)	**Maintenance Dose:** ◯ **Adolescents weighing less than 60kg:** Inject 200mg SQ every 2 weeks ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 300mg SQ every 2 weeks	
◯ **ENBREL®** ◯ Mini® ◯ PFS ◯ SureClick® ◯ Vial	◯ 6 cartons (24x50mg/mL)	◯ **Starter Dose:** Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months	**No Refills**
	◯ 1 carton (4x50mg/mL)	◯ **Maintenance Dose:** Inject 50 mg SQ every week	
	◯ **PFS:** 1 carton (4x25mg/0.5mL) ◯ **Vial:** 1 carton (4x25mg/mL)	◯ **Pediatric Dose:** < 63 kg (138 lbs) Inject _____ mg (0.8mg/kg) SQ once a week ◯ **Pediatric Dose:** > 63 kg (138 lbs or more) Inject 50 mg SQ once a week	
◯ **HUMIRA®** (Plaque Psoriasis) ◯ Pens ◯ PFS	**Pens Only:** ◯ Starter Kit (4x40mg/0.8mL) ◯ Citrate-Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	◯ **Starter Dose:** Inject 80 mg SQ Day 1, then 40mg on day 8, then 1 pen every 2 weeks	**No Refills**
	◯ 1 carton (2x40mg/0.8mL) ◯ Citrate Free: 1 carton (2x40mg/0.4ml)	◯ **Maintenance Dose:** Inject 40 mg SQ every 2 weeks	
◯ **HUMIRA®** (Hidradenitis Suppurativa) ◯ Pens ◯ PFS	**Pens Only:** ◯ Starter Kit (6x40mg/0.8ml) ◯ Citrate-Free Starter Kit (3x80mg/0.8ml)	**Starter Dose:** ◯ **Adolescents weighing 30-59kg:** Inject 80mg SQ on day 1, 40mg on day 8 and 40mg on day 22 ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 160mg SQ day 1 (or 80mg SQ on day 1 and day 2); then 80mg on day 15; then begin maintenance dosing on day 29	**No Refills**
	◯ 2 cartons (4x40mg/0.8mL) ◯ Citrate Free: 2 cartons (4x40mg/0.4ml)	**Maintenance Dose:** ◯ **Adolescents weighing 30-59kg:** Inject 40mg SQ **every other** week ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 40mg SQ **every** week	
◯ **ILUMYA™**	◯ 1 carton (1x100mg/mL PFS)	◯ **Starter Dose:** Inject 100mg SQ at weeks 0 and 4	**No Refills**
		◯ **Maintenance Dose:** Inject 100mg SQ every 12 weeks	

Injection Training

◯ Patient received pens and injection training ◯ Physician's office to provide injection training ◯ VascoRx to coordinate injection training or infusion

By signing this form and utilizing our services, you are authorizing VascoRx and its employees to serve as your prior authorization agent in dealing with medical and prescription insurance companies and copay assistance foundation.

Prescriber Signature: Date Substitution Permitted	Prescriber Signature: Date Dispense as Written