DERMATOLOGY ENROLLMENT FORM

PHONE: 800-361-1260
FAX: 800-737-4920

CORNERSTONE PHARMACY
an affiliate of
MEDICAL CENTRE PHARMACY

PATIENT INFORMATION (PLEASE PRINT)

Patient Name (Last, First, Middle Initial)			☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	SS#	Phone (Daytime)	Phone (Evening)
Street Address (Please include Suite/Apt Number)		City	State / Zip

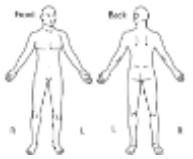
INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK)

Primary Insurance		Policy Holder
Policy #	Group #	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)

☐ 696.1 Psoriasis ☐ 696.0 Psoriasis Arthritis ☐ Other ICD9 _____

____ BSA % by Psoriasis



Is patient new to therapy? ☐ yes ☐ no Date of Diagnosis: _____/_____/_____

Patient tested for TB: ☐ yes ☐ no If yes, Result: ☐ Positive ☐ Negative

Phototherapy performed: ☐ yes ☐ no | Drug Allergies: _____ OR ☐ NKDA | Patient Weight: _____

Psoriasis Severity ☐ Moderate ☐ Moderate to Severe ☐ Severe | Psoriasis Type ☐ Plaque ☐ Other:_____

PREVIOUS (FAILED) MEDICATIONS (Please specify dosage and time on therapy)

Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION

Rx-Medication	*Dose and Frequency*		*Quantity*	*Refills*
☐ Enbrel® (etanercept)	☐ 50 mg/ml prefilled syringe ☐ 50 mg/ml SureClick™ Autoinjector ☐ 25 mg/0.5ml prefilled syringe ☐ 25 mg vial	☐ Psoriasis Induction Dose: Inject 50 mg SC twice a week (3-4 days apart) for 3 months ☐ 50mg SC once a week ☐ 50mg SC twice a week ☐ 25mg SC twice a week		
☐ Humira® (adalimumab)	☐ Psoriasis Starter Package	☐ *Starter Dose:* Inject two (2) 40mg SC on day 1; then, one (1) 40mg on day 8; then, one (1) 40mg every other week	1	**0**
	☐ 40mg/0.8ml prefilled syringe ☐ 40mg/0.8ml Pen	☐ *Maintenance:* 40mg SC every other week		
☐ Stelara™ (Ustekinumab)	☐ 45mg/0.5 ml pre-filled syringe ☐ 90mg/1.0 ml pre-filled syringe	☐ Administered SC under the supervision of a physician. 1st dose, then 4 weeks later, then every 12 weeks.		
☐ Simponi™ (infliximab)	☐ 50mg/0.5ml ☐ 50mg/0.5ml	☐ 50 mg SC once per month		
☐ Specialty Compound	☐ _____			

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS

☐ Patient's Home ☐ Physician's Office | Date Needed | Patient needs Education Kit? ☐ yes ☐ no

Teaching to be done at: ☐ Patient's Home ☐ Physician's Office ☐ Not needed

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION

Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Street Address (Please include Suite Number)		City/State/Zip	
Physician's Signature (required)		**Date (required)**	

This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right. ☐