Dermatology Enrollment Form

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Toll Free Fax: 866-217-8034
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MAXOR® SPECIALTY

PATIENT INFORMATION

Patient Name _____
Date of Birth _____ ◯ Male ◯ Female
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Phone-Primary _____ Secondary _____
◯ English ◯ Spanish ◯ Other _____
Email Address _____
Social Security # _____
◯ NKDA Known Drug Allergies _____
Weight _____ kg/lb Height _____ in/cm

Please attach front and back of patient's insurance cards

PHYSICIAN INFORMATION

Physician Name _____
NPI _____ License # _____
Office Contact _____
Street Address _____ Ste # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

By signing this form, I authorize Maxor Specialty to act as my agent for prior authorizations & prescription reimbursement for the above listed patient.

Physician Signature _____
Date _____

◯ Dispense as written ◯ Product substitution permitted

** For Ohio patients, please only choose one (1) prescription/form.**

CLINICAL INFORMATION

Diagnosis: ◯ L40.8 Moderate to Severe Plaque Psoriasis ◯ L40.5 Psoriatic Arthritis ◯ L73.2 Hidradenitis Suppurativa-Hurley Stage
◯ Other _____ Condition _____
Location: ◯ Face ◯ Feet ◯ Groin ◯ Hands ◯ Nails ◯ Scalp ◯ Other _____
Severity: ◯ Moderate ◯ Moderate to Severe ◯ Severe BSA _____ %
Prior (FAILED) Medications: ◯ Biologics ◯ Methotrexate ◯ Oral Meds ◯ PUVA
◯ UVB ◯ Topicals ◯ Other(please specify) _____
TB Test: ◯ Yes ◯ No Results: _____
Injection Training/Home Health:
◯ Specialty Pharmacy to coordinate injection training ◯ Home health nurse to visit as necessary ◯ Injection training not necessary
Additional Comments: _____

PRESCRIPTION INFORMATION

CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM ◯

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
◯ **Cosentyx®**	◯ 300mg (2X150) ◯ 150mg ◯ Pen ◯ PFS	**Intial Dose:** ◯ Inject 150 mg SQ at wk 0, 1, 2, 3, 4 ◯ Inject 300 mg SQ at wk 0, 1, 2, 3, 4 **Maintenance Dose:** ◯ Inject 150 mg SQ every 4 wks ◯ Inject 300 mg SQ every 4 wks		
◯ **Enbrel®**	◯ 50mg Sureclick ◯ 50mg PFS ◯ 25mg PFS ◯ 25mg Vials	**Initial Dose:** ◯ Inject 50mg SQ twice a wk (72-96 hrs apart) X 3 months **Maintenance Dose:** ◯ Inject 50mg SQ every other wk ◯ Inject 25mg SQ twice a wk (72-96 hrs apart)		
◯ **Humira®**	◯ Psoriasis Starter Kit ◯ 40mg Pen ◯ 40mg PFS	**Initial Dose:** ◯ Inject 2-40mg (80mg) on day 1, 40mg on day 8, then 40mg every other wk **Maintenance Dose:** ◯ Inject 40mg SQ every other wk thereafter		
◯ **Humira® HS**	◯ HS Starter Package ◯ 40mg Pen ◯ 40mg PFS	**Intial Dose:** 160mg given as: ◯ Four 40mg SQ day 1 "OR" ◯ Two 40mg SQ days 1 & 2 then inject 80mg (two 40mg) SQ on day 15 **Maintenance Dose:** ◯ Wk 4 +: Inject 40mg SQ wkly		
◯ **Otezla®**	◯ Starter Pack ◯ 30mg Tablets	◯ Take 1 tablet on day 1 then twice daily as directed or date provided _____ ◯ Take 1 tablet by mouth twice daily		
◯ **Remicade®**	◯ 100mg Vial	**Initial Dose:** ◯ Infuse 5mg/kg at wk 0,2,6 **Maintenance Dose:** ◯ Infuse 5mg/kg Q 8 wks		
◯ **Simponi®**	◯ 50mg Smartject ◯ 50mg PFS	◯ Inject 50mg SQ once a month as directed		
◯ **Stelara®**	◯ 45mg PFS ◯ 90mg PFS	◯ Inject 45mg on day 0, then wk 4, then every 12 wks (Patients ≤ 220lbs) * for patients with psoriatic authritis with no plaque psoriasis, give 45mg regardless of weight ◯ Inject 90mg on day 0, then wk 4, then every 12 wks (Patients > 220lbs)		
◯ **Other**				

Date meds needed: _____ ◯ New ◯ Refill
Ship to: ◯ Patient's home ◯ Physician's Office ◯ Other _____

Revised 06/2016