

Patient Intake Form-DERMATOLOGY

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TODAY'S DATE _____ DATE NEEDED _____

| PATIENT INFORMATION | | | |
|--|-------------|---|------|
| First: | Last: | M.I.: | |
| Date of Birth: | SSN: | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Best Phone: | Alt. Phone: | Email: | |
| Address: | City: | State: | Zip: |
| Shipping Address (if different from home address): | | | |

| PRESCRIBER INFORMATION | | | |
|------------------------|--------------|-------------|------|
| First: | Last: | M.I.: | |
| DEA#: | Med. Lic. #: | NPI#: | |
| Office Contact: | Phone: | Alt. Phone: | |
| Address: | City: | State: | Zip: |

| INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS) | | | | | |
|---|--------|---------|------------|----------|--------|
| Primary: | PCN: | BIN# | Secondary: | PCN: | ID#: |
| Phone: | ID#: | Group# | Phone: | BIN# | Group# |
| Prescription Drug Insurer: | Phone: | RxGrp#: | RxBIN#: | PCN/ID#: | |

| CLINICAL INFORMATION | |
|---|--|
| TB Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Date _____ | If positive has patient been treated? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Primary Diagnoses: <input type="checkbox"/> Psoriatic Arthropathy ICD 696 <input type="checkbox"/> Other Psoriasis and similar disorders ICD 696.1 <input type="checkbox"/> Other _____ | |
| Allergies: | |
| Failed Therapies and Dates: | |
| Current Therapies/Medications: | |
| Will patient stop taking the above medications before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what is the washout period? |
| Does the patient have any co-morbid infections? <input type="checkbox"/> Yes <input type="checkbox"/> No | Plaque Psoriasis Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe |

| <input checked="" type="checkbox"/> PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY) | | |
|---|---|--|
| <p>Enbrel® Dosing for RA, Psoriatic Arthritis: <input type="checkbox"/> 50mg SC weekly <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick</p> <p>Enbrel® Starting Dose for Plaque Psoriasis: <input type="checkbox"/> 50mg SC BIW for 3 months then weekly <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick</p> <p><input type="checkbox"/> 25mg SC BIW <input type="checkbox"/> PFS <input type="checkbox"/> Vial</p> <p>Enbrel® Maintenance Dosing for Plaque Psoriasis: <input type="checkbox"/> 50mg SC q week x _____ refills <input type="checkbox"/> 25mg SC twice weekly x _____ refills <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p> <p>Simponi® 50mg/0.5ml SC once a month <input type="checkbox"/> Pre-filled SmartJet™ AutoJet single dose <input type="checkbox"/> Pre-filled syringe single dose Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p> | <p>Humira® Starting dose for Psoriasis: 80mg SC x one initial dose then 40mg SC every other week starting one week after initial dose. <input type="checkbox"/> Starter Kit Pen <input type="checkbox"/> PFS #4</p> <p>Humira® Maintenance Dosing: Humira® 40mg SC every other week <input type="checkbox"/> Pen or <input type="checkbox"/> PFS <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____ <input type="checkbox"/> Year Other: _____</p> <p>Other Medication Name: _____ Strength: _____ Directions: _____ Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p> | <p>Remicade® (Must be shipped to MD office) Remicade® Starting Dose: _____mg/kg IV at 0,2,6 weeks Remicade® Maintenance Dosing: _____mg/kg IV Q 8 weeks <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p> <p>Stelara® PFS (Must be shipped to MD office) Stelara® Starting Dose: (For patients weighing < 100kg) <input type="checkbox"/> 45mg SC x 1 followed by 45mg SC in 4 weeks (For patients weighing > 100kg) <input type="checkbox"/> 90mg SC x 1 followed by 90mg SC in 4 weeks Stelara® Maintenance Dosing: <input type="checkbox"/> 45mg SC every 12 weeks <input type="checkbox"/> 45mg SC every 12 weeks Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p> |

| ADDITIONAL INSTRUCTIONS | |
|--|-------|
| Please Deliver To: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Dr.'s Office <input type="checkbox"/> 1 st dose to MD's office, remaining refills to patient's home | |
| Physician's Signature: | Date: |