XUBEX® Specialty Pharmacy Services
www.Xubex.com

# Patient Intake Form-DERMATOLOGY

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TODAY'S DATE_____ DATE NEEDED_____

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First: | Last: | M.I.: | |
| Date of Birth: | SSN: | ☐Male ☐ 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: ☐ Negative ☐ Positive Date_____ | If positive has patient been treated? ☐ Yes ☐ No

Primary Diagnoses: ☐ Psoriatic Arthropathy ICD 696 ☐ Other Psoriasis and similar disorders ICD 696.1 ☐ Other_____

Allergies:

Failed Therapies and Dates:

Current Therapies/Medications:

Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No | If yes, what is the washout period?

Does the patient have any co-morbid infections? ☐ Yes ☐ No | Plaque Psoriasis Severity: ☐ Mild ☐ Moderate to Severe ☐ Severe

## ☑ PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)

**Enbrel®**

**Dosing for RA, Psoriatic Arthritis:**

☐ 50mg SC weekly ☐ PFS ☐ Sureclick

**Enbrel® Starting Dose for Plaque Psoriasis:**

☐ 50mg SC BIW for 3 months then weekly
☐ PFS ☐ Sureclick

☐ 25mg SC BIW ☐ PFS ☐ Vial

**Enbrel® Maintenance Dosing for Plaque Psoriasis:**

☐ 50mg SC q week x_____refills

☐ 25mg SC twice weekly x_____refills

☐ Other:_____

Qty:_____ Refills:_____ ☐ 1Year

**Simponi®**

**50mg/0.5ml SC once a month**

☐ Pre-filled SmartJet™ AutoJet single dose

☐ Pre-filled syringe single dose

Qty:_____ Refills:_____ ☐ 1 Year

**Humira®**

**Starting dose for Psoriasis:**

80mg SC x one initial dose then 40mg SC every other week starting one week after initial dose.

☐ Starter Kit Pen ☐ PFS #4

**Humira® Maintenance Dosing:**

Humira® 40mg SC every other week

☐ Pen or ☐ PFS

☐ Other:_____

Qty:_____ Refills:_____ ☐ Year

Other:_____

**Other**

Medication Name: _____

Strength: _____

Directions:_____

Qty:_____ Refills:_____ ☐ 1 Year

**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

☐ Other:_____

Qty: _____ Refills: _____ ☐ 1 Year

**Stelara®** PFS (Must be shipped to MD office)

**Stelara® Starting Dose:**

(For patients weighing < 100kg)

☐ 45mg SC x 1 followed by 45mg SC in 4 weeks

(For patients weighing > 100kg)

☐ 90mg SC x 1 followed by 90mg SC in 4 weeks

**Stelara® Maintenance Dosing:**

☐ 45mg SC every 12 weeks

☐ 45mg SC every 12 weeks

Qty:_____ Refills:_____ ☐ 1 Year

## ADDITIONAL INSTRUCTIONS

**Please Deliver To:** ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home

| | |
|---|---|
| **Physician's Signature:** | Date: |