Whole Health Pharmacy

Dermatology Enrollment Form

Fax: 949-340-8008 Phone: 949-305-0788

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

City, State, Zip _____

Home Phone _____ Mobile Phone _____

DOB _____ Last Four of SS _____ Gender _____

Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____

DEA _____

NPI _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis / ICD 10: | % of BSA affected?

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ **Cibinqo**	□ 50mg tablets □ 100mg tablets □ 200mg tablets	□ Take 1 tablet by mouth once daily	□ 30 tabs	□ 1 □ 2 □ 3 □ 4 □ 11 □ ___
□ **Cimzia**	□ Starter kit □ 200mg/ml PFS □ 200mg lyophilized vial	□ 400mg SQ weeks 0, 2, 4 □ 200mg SQ every 2 weeks □ 400mg SQ every 4 weeks	□ 1 kit □ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Cosentyx**	□ 150mg prefilled Syringe □ 150mg Sensoready Pen	□ 300mg SQ at weeks 0, 1, 2, 3, & 4 followed by 300mg SQ every 4 weeks (PSO) □ 300mg SQ every 4 weeks □ 150mg SQ at weeks 0, 1, 2, 3, & 4 followed by 300mg SQ every 4 weeks (PSA) □ 150mg SQ every 4 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Enbrel**	□ 25mg/ml □ 50mg/ml Sureclick autoinjector □ 50mg/ml PFS □ 50mg Mini Cartridge	□ 50mg SQ twice weekly for 3 months □ 50mg SQ once weekly □ 25mg SQ once weekly	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Humira CF**	□ Psoriasis Starter pack □ 40mg/0.4ml Pen □ 40mg/0.4ml PFS □ 80MG/0.8ML Pen □ Crohn/ UC/ HS Starter pack	□ Inject 40mg SQ every other week □ Inject 40mg SQ once weekly □ Inject 80mg SQ on day 1 then inject 40mg on day 8 then inject 40mg every other week thereafter (Psoriasis Starter pack) □ Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose (Crohn's/HS Starter pack)	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Ilumya**	□ 100mgl prefilled syringe	□ 100mg SQ at weeks 0 & 4 followed by 100 mg every 12 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Otezla**	□ Starter Pack □ 30mg tablets	□ Take are directed □ Take 30mg PO twice daily □ Take 30mg PO once daily	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Rinvoq**	□ 15mg tablets □ 30mg tablets	□ Take 15mg PO once daily □ Take 30mg PO once daily	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ___
□ **Siliq**	□ 210mg/1.5ml PFS	□ 210mg SQ at weeks 0, 1, & 2 followed by 210mg every 2 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Simponi**	□ 50mg/0.5ml SmartJect autoinjector □ 50mg/0.5ml PFS	□ Inject 50mg SQ every 4 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Skyrizi**	□ 75mg/0.83mL prefilled syringe	□ Inject 150mg SQ at week 0, 4, and every 12 weeks thereafter □ Inject 150mg SQ every 12 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Stelara**	□ 45mg/0.5ml PFS □ 90mg/0.5ml PFS	□ Inject 1 syringe SQ on days 0 and 28 (starter dose) □ Inject 1 syringe SQ every 12 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Taltz**	□ 80mg Auto-Injector Starter Kit (3 pens) □ 80mg Auto-Injector (2 pens) □ 80mg Auto-Injector (1 pen) □ 80mg Prefilled Syringe (1 syringe)	□ 160mg SQ on day 1, then followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, and then 80mg every 4 weeks □ 80mg SQ every 4 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Tremfya**	□ 100mg Pen □ 100mg PFS	□ Inject 100mg SQ at week 0, 4, and every 8 weeks thereafter □ Inject 100mg SQ every 8 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Adbry**	□ 150mg/ml PFS	□ Inject 600mg SQ followed by 300mg every 2 weeks (Initial) □ Inject 300mg SQ every 2 weeks (maintenance) □ Inject 300mg SQ every 4 weeks for patients below 100kg who achieve clear skin after 16 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 11 □ ___
□ **Dupixent**	□ 300mg/2ml Pen □ 300mg/2ml PFS □ 200mg/1.14ml PFS	□ Inject 600mg SQ followed by 300mg every 2 weeks □ Inject 300mg SQ every 2 weeks □ Inject 400mg SQ followed by 200mg every 2 weeks □ Inject 200mg SQ every 2 weeks	□ 28 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Eucrisa**	□ 2% Ointment	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Opzelura**	□ 1.5% Cream	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ ___
□ **Protopic**	□ 0.03% Ointment □ 0.1% Ointment	□ Apply 1 application to affected area(s) 2 times daily	□ 30gm □ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Elidel**	□ 1% Cream	□ Apply 1 application to affected area(s) 2 times daily	□ 30gm □ 60gm □ 100gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ **Calcipotriene**	□ 0.005% Cream □ 0.005% Ointment	□ Apply 1 application to affected area(s) 2 times daily	□ 60gm □ 120gm	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____

Ship to: □ Patient □ Office □ Other _____ Date: _____ Need by Date _____

**** Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____ Date: _____