Dermatology Enrollment Form

Lumicera Health Services
2601 West Beltline Hwy, Ste 302, Madison, WI 53713 | 5350 E High St, Suite 200, Phoenix, Arizona - 85054-5465 | Phone: (855) 847-3553 / Fax: (855) 847-3558

Ship to: ○ Patient ○ Office ○ Other

Date: Needs by Date:

PATIENT INFORMATION

Patient Name ______
Address ______
Address 2 ______
City, State, ZIP ______
Preferred Phone ______ Type ______
Alternate Phone ______ Type ______
Email ______
DOB (mm/dd/yyyy) ______ Gender ○ Male ○ Female

PRESCRIBER INFORMATION

Prescriber Name ______ Specialty ______
State License # ______ UPIN ______
DEA ______ NPI ______
Group/Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Office Contact ______ Phone ______

INSURANCE INFORMATION *(Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical)*

CLINICAL INFORMATION

Diagnosis (*Please include diagnosis name and ICD-10 code)*

Primary Diagnosis: ○ Plaque ○Psoriasis ○Hidradenitis Suppurativa
○Atopic Dermatitis ○ Other Diagnosis: ______
ICD-10: ______
Date of Diagnosis: ______
Weight: ______ lbs/kgs Height :______ in/cm ______
Is the patient pregnant, nursing, or planning pregnancy?: ○Yes ○No ○N/A
Date of last TB test (PPD or QuantiFERON Gold): ______
Results: ○Positive ○Negative
Allergies: ______
Concomitant medications: ______

Therapy: ○ New ○ Continuing Therapy ○ Restart
BSA %: ______
Affected Areas: ______
Has the patient been previously treated for this condition? ○Yes ○No
Prior failed medication (medication and duration of treatment/reason for d/c):
______
Who will administer injection? (if applicable): ______
Patient trained on injection? (if applicable): ○Yes ○No
Pharmacy injection training needed? (if applicable): ○Yes ○No
Additional comments: ______
______

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
○ Cosentyx® (secukinumab)	○ 150mg/ml prefilled syringe ○ 150mg/ml Sensoready Pen	○ 300mg subcutaneously at week 0, 1, 2, 3, and 4 ○ 300mg subcutaneously every 4 weeks ○ Other:______	10	0
○ Dupixent® (secukinumab)	○ 300mg/2ml prefilled syringe	○ 600mg subcutaneously initially ○ 300mg subcutaneously every other week	2 2	0
○ Enbrel® (etanercept)	○ 25mg/0.5ml multi-dose vial ○ 25mg/0.5ml prefilled syringe ○ 50mg/ml prefilled syringe ○ 50mg/ml SureClick Pen ○ 50mg/ml Mini Cartridge	○ 50mg twice weekly X 12 weeks, then once weekly ○ 50mg subcutaneously once weekly ○ ____mg (0.8mg/kg x ____kg) subcutaneously once weekly (peds ≤63kg) ○ Other:______		
○ Humira® (adalimumab)	○ 40mg/0.8ml prefilled syringe ○ 40mg/0.8ml pen	○ 80mg subcutaneously on day 1, 40mg on day 8, then 40mg every 2 weeks (Psoriasis Starter Kit) ○ 160mg subcutaneously on day 1, 80mg on day 15, then 40mg weekly starting on day 29 (Hidradenitis Starter Kit) ○ 40mg subcutaneously every other week ○ 40mg subcutaneously once weekly ○ Other:______	4 6	0 0
○ Otezla® (apremilast)	○ 10/20/30mg tablet starter ○ 30mg tablet	○ Take as directed per package instructions ○ 30mg by mouth twice daily ○ Other:______	55 60	 0
○ Siliq (brodalumab)	○ 210mg/1.5ml prefilled syringe	○ 210mg subcutaneously on week 0, 1, 2 ○ 210mg subcutaneously every 2 weeks	3	0
○ Stelara® (ustekinumab)	○ 45mg/0.5ml prefilled syringe (≤100kg) ○ 90mg/ml prefilled syringe	○ 45mg subcutaneously initially and 4 weeks later ○ 45mg subcutaneously every 12 weeks ○ 90mg subcutaneously initially and 4 weeks later ○ 90mg subcutaneously every 12 weeks	2 1 2 1	0 0
○ Taltz® (ixekizumab)	○ 80mg/ml prefilled syringe ○ 80mg/ml autoinjector pen	○ 160mg subcutaneously initially, then 80mg every 2 weeks for 3 months ○ 80mg subcutaneously every 4 weeks ○ Other:______	8 1	0
○ Tremfya™ (guselkumab)	○ 100mg/1ml prefilled syringe	○ 100mg subcutaneously on week 0, and week 4 ○ 100mg subcutaneously every 8 weeks	2 1	0

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: ______ *PRODUCT SUBSTITUTION PERMITTED* ______ *Date* ______ *DISPENSE AS WRITTEN*