

Patient Intake Form-DERMATOLOGY

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

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: 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)

<p>Enbrel® Dosing for RA, Psoriatic Arthritis: <input type="checkbox"/> 50mg SC weekly <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick 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 <input type="checkbox"/> 25mg SC BIW <input type="checkbox"/> PFS <input type="checkbox"/> Vial 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 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>
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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: _____