XUBEX® Specialty Pharmacy Services
www.Xubex.com

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:	☐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: