

# Patient Intake Form-DERMATOLOGY

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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: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Date _____	If positive has patient been treated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Diagnoses: <input type="checkbox"/> Psoriatic Arthropathy ICD 696 <input type="checkbox"/> Other Psoriasis and similar disorders ICD 696.1 <input type="checkbox"/> Other _____	
Allergies:	
Failed Therapies and Dates:	
Current Therapies/Medications:	
Will patient stop taking the above medications before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the washout period?
Does the patient have any co-morbid infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	Plaque Psoriasis Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe

<input checked="" type="checkbox"/> PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)		
<p><b>Enbrel®</b> <b>Dosing for RA, Psoriatic Arthritis:</b> <input type="checkbox"/> 50mg SC weekly <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick</p> <p><b>Enbrel® Starting Dose for Plaque Psoriasis:</b> <input type="checkbox"/> 50mg SC BIW for 3 months then weekly <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick</p> <p><input type="checkbox"/> 25mg SC BIW <input type="checkbox"/> PFS <input type="checkbox"/> Vial</p> <p><b>Enbrel® Maintenance Dosing for Plaque Psoriasis:</b> <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><b>Simponi®</b> <b>50mg/0.5ml SC once a month</b> <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><b>Humira®</b> <b>Starting dose for Psoriasis:</b> 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</p> <p><b>Humira® Maintenance Dosing:</b> 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><b>Other</b> Medication Name: _____ Strength: _____ Directions: _____ Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p>	<p><b>Remicade®</b> (Must be shipped to MD office) <b>Remicade® Starting Dose:</b> _____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><b>Stelara®</b> PFS (Must be shipped to MD office) <b>Stelara® Starting Dose:</b> (For patients weighing &lt; 100kg) <input type="checkbox"/> 45mg SC x 1 followed by 45mg SC in 4 weeks (For patients weighing &gt; 100kg) <input type="checkbox"/> 90mg SC x 1 followed by 90mg SC in 4 weeks <b>Stelara® Maintenance Dosing:</b> <input type="checkbox"/> 45mg SC every 12 weeks <input type="checkbox"/> 45mg SC every 12 weeks Qty: _____ Refills: _____ <input type="checkbox"/> 1 Year</p>

ADDITIONAL INSTRUCTIONS	
Please Deliver To: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Dr.'s Office <input type="checkbox"/> 1 <sup>st</sup> dose to MD's office, remaining refills to patient's home	
Physician's Signature:	Date: