WELLPARTNER PHARMACY | DERMATOLOGY ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /
Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ L40.0 Psoriasis vulgaris
◯ L40.59 Other psoriatic arthropathy
◯ Other:

Psoriasis Severity: ◯ Moderate ◯ Moderate to severe ◯ Severe
Type of Psoriasis: ◯ Plaque ◯ Other:

Prior (failed) medications	Reason for discontinuation
◯ Biologics:	
◯ Oral meds:	
◯ Topicals:	
◯ Other:	

Allergies
Other Medications:
Height (in/cm): _____ Weight (lb/kg): _____

PATIENT EVALUATION

Has patient been diagnosed with heart failure? ◯ Yes ◯ No
Does patient have a latex allergy? ◯ Yes ◯ No
Has patient been diagnosed with lymphoma? ◯ Yes ◯ No
Does patient have a serious/active infection? ◯ Yes ◯ No
Has TB test been performed? ◯ Yes ◯ No If yes, results:
Is patient platelet count >52,000 cells/uL? ◯ Yes ◯ No
Hepatitis B has been ruled out or treatment has been initiated. ◯ Yes ◯ No
BSA % affected by psoriasis: _____ %
Specialty pharmacy to coordinate injection training/home health nurse visit as necessary. ◯ Yes ◯ No Agency of choice:

◯ Injection training is not necessary.
Reason: ◯ MD office trained patient — Date: / /
◯ Referred by MD office to alternate trainer
◯ Patient already independent

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
◯ Enbrel®	◯ 50 mg/ml Sureclick Autoinjector ◯ 50 mg/ml prefilled syringe ◯ 25 mg/0.5 ml prefilled syringe ◯ 25 mg vial	◯ Psoriasis induction dose: Inject 50 mg subcutaneously twice a week (3-4 days apart) for 3 months, then maintenance dosing. ◯ Psoriasis maintenance dose/Psoriatic arthritis dose: Inj. 50 mg subcutaneously once a wk. ◯ Other:		
◯ Humira®	◯ Psoriasis starter package	◯ Psoriasis induction dose: Inject two 40 mg pens/syringes subcutaneously on day 1, then one 40 mg pen/syringe on day 8, then one 40 mg pen every other week.	1	0
	◯ 40 mg/0.8 ml pen ◯ 40 mg/0.8 ml prefilled syringe	◯ Inject one 40 mg pen/syringe subcutaneously every other week. ◯ Other:		
◯ Remicade®	◯ 100 mg vial	◯ Infuse 5 mg/kg in 250 ml 0.9% NaCl at wk 0, wk 2, wk 6, and every 8 wks thereafter. ◯ Infuse 5 mg/kg in 250 ml 0.9% NaCl every 8 wks. ◯ Other:		
◯ Simponi®	◯ 50 mg/0.5 ml SmartJect Autoinjector ◯ 50 mg/0.5 ml prefilled syringe	◯ Psoriatic arthritis dose: Inject 50 mg (0.5 ml) subcutaneously once a month. ◯ Other:		
◯ Stelara™	◯ 45 mg/0.5 ml prefilled syringe ◯ 90 mg/ml prefilled syringe	◯ Inject _____ mg initially and 4 wks later, followed by _____ mg every 12 wks. ◯ Other:		
◯ Cosentyx®	◯ Carton of two 150 mg/ml single-use Sensoready® pens (inj.) ◯ Carton of one 150 mg/ml single-use Sensoready® pen (inj.) ◯ Carton of two 150 mg/ml single-use prefilled syringes (inj.) ◯ Carton of one 150 mg/ml single-use prefilled syringe (inj.)	◯ Psoriasis Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4 ◯ Psoriasis Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks. ◯ Other:		
◯ Otezla®	◯ Titration Starter Pack Rx ◯ 30 mg tablet	◯ Titration pack: Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily. ◯ 30 mg tablet: Take 1 tablet by mouth twice daily. ◯ Other:	1 pack	
◯ Taltz® (LD)*	(LD)* This is a limited distribution drug that requires additional handling. Please call (1.800.473.3516) for more information.			

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE