Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

Dermatology Enrollment Form (O-Z)

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821 Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date:______________ **Ship to :** ___ Patient ___ Office __________ Other

Patient Name:____ Male / Female DOB:_____________

Address:____

Soc. Sec. # ____________________ Phone #:____________________ Alt Phone #:____________________

Caregiver:____________________________ Allergies:____

Comorbidities: ______________________________________ Height:___________ Weight: ____________

2. Clinical Information *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:__________________ TB Test: yes / no Date of Negative Result:_____________

Prior Therapies: ______________________________ Reason for Discontinuation:____________________

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Odomzo®	__ 200mg capsule	__ take 1 capsule per day 2 hours after last meal	__ 330 capsules	
	Otezla®	Starter Dose: __ 4wk start pack (10/20/30mg)	__ take as directed on (28 day Starter Pack) package __	__ Starter pack (55 tabs)	
		Maintenance Dose: __ 30mg tablet	__ take 1 tablet by mouth twice a day __	________Tablets	
	Oxsoralen-Ultra®	__ 10mg capsule	__ take ______mg orally _____ hours before UVA exposure __	______ Capsules	
	Rhofade®	__1% cream	__ Apply once daily	__ 30 grams	
	Siliq®	__ 210mg/ 1.5mL	__ Inject 210 mg Sub-Q on wks 0,1& 2; followed by 210 mg Sub-Q every 2 weeks thereafter __ Inject 210 mg Sub-Q every 2 weeks	__ 2 PFS __ 4 PFS	
	Simponi®	__ 50mg/0.5mL	__ Inject 50 mg Sub-Q once a month	______ PFS ______ SmartJect®	
	Stelara®	Starter Dose __ 45mg/ 0.5mL SDV __ 45mg/ 0.5mL PFS __ 90mg /1 mL PFS	__ Inject 0.75 mg/kg x ______ kg Sub-Q on Day 1(<60kg) __ Inject 45 mg Sub-Q on Day 1 (60-100kg) __ Inject 90 mg Sub-Q on Day 1 (>100kg)	__ 1 PFS __ 1 Vial	
		Maintenance Dose __ 45mg/ 0.5mL SDV __ 45mg/ 0.5mL PFS __ 90mg /1 mL PFS	__ Inject 0.75mg/kgx______ kg Sub-Q on Day 29 &every 12wks after __ Inject 45 mg Sub-Q on day 29 & every 12wks after __ Inject 90 mg Sub-Q on day 29 & every 12wks after __ Inject __________ mg every 12 weeks	__ 1 PFS __ 1 Vial __	
	Targretin® (gel)	__ 1% gel	__ Apply gel every other day for 1 wk, then at weekly intervals: increase to 1x daily; then 2x daily; then 3x daily; then 4x daily. __	__ 60 grams	
	Tremfya®	__ 100mg/mL PFS	__ Inject 100mg Sub-Q at week 0 __ Inject 100mg Sub-Q at week 4 and every 8 weeks after __ Inject 100mg Sub-Q every 8 weeks	__ 1 PFS __	

4. Prescriber and Shipping Information

Pref. Method of Contact: __ phone __ fax __ email

Prescriber (print): ______________________________________ Office Contact: ____________________

Contact email:________________________________ Phone: ____________________ Fax:________________

Office Address: ____

NPI:_______________________________________ DEA: _____________________________________

Prescriber's Signature: ____ Date:______________

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

IMPORTANT NOTICE:this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.

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