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

AccuSERV® PHARMACY

Dermatology Enrollment Form (P-Z)

Clear Form

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
	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

Prescriber (print) : _____ Office Contact: _____

Pref. Method of Contact: ◯ phone ◯ fax ◯ email Contact email:_____

Office Address: _____

Phone: _____ Fax: _____

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.

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