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

AccuSERV® PHARMACY

Dermatology Enrollment Form (A-N)

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
	Cimzia® *(for PsA)*	○ Starter Kit ○ 200mg / mL PFS	Starter Dose ○ inject 400mg Sub-Q at weeks 0,2 & 4	○ Starter kit 6PFS	
			Maintenance Dose ○ inject _____ mg Sub-Q every _____ weeks	○ 2 PFS ○	
	Dupixent®	○ 300mg/2mL PFS	○ inject 600mg Sub-Q divided in 2 different injection sites ○ inject 300mg Sub-Q every other week ○	○ 2 PFS ○	
	Enbrel®	○ 25mg/0.5mL PFS ○ 25mg Vial ○ 50mg/mL *SureClick®* ○ 50mg/mL PFS ○ 50mg/mL 0.98mL (Mini)	○ inject 25mg Sub-Q once a week ○ inject 50mg Sub-Q once a week ○ inject 50mg Sub-Q twice a week (72-96hrs apart) ○	○ 4 *SureClick®* ○ 4 PFS ○ 4 Vials ○ 4 *Enbrel Mini®* ○	
	Eucrisa®	○ 2% ointment	○ apply topically to _____, _____ times a day for ____ days	○ 60g	
	Humira® *(for Plaque Psoriasis)*	○ 40mg/ 0.8mL Pen ○ 40mg/ 0.8mL PFS ○	○ inject 80mg Sub-Q Day1 then 40mg Sub-Q Day 8, then 40mg Sub-Q every 2 weeks after ○ inject 40mg Sub-Q every other week ○	○ 2 Pens ○ 2 PFS ○ 4 Pens ○	
	Humira® *(for Hidradenitis Suppurativa)*	○ 40mg/ 0.8mL Pen ○ 40mg/ 0.8mL PFS ○	○ inject 160mg Sub-Q Day 1 then 80mg Sub-Q Day 15 ○ inject 80mg Sub-Q Day 1 then 80mg Sub-Q Day 2 then 80mg Sub-Q on day 15 ○ starting on Day 29, inject 40mg Sub-Q every wk ○	○ 2 Pens ○ 2 PFS ○ 4 Pens ○	

4. Prescriber and Shipping Information

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

Prescriber (print): _____ Office Contact: _____

Contact email: _____ Phone: _____

Office Address: _____

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.