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

AccuSERV® PHARMACY

Dermatology Enrollment Form (O-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
☐	Odomzo®	○ 200mg capsule	○ take 1 capsule per day 2 hours after last meal	○ 30 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	
☐	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.

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