DERMATOLOGY Enrollment Form

CLEAR

ENCOMPASS Rx
Leaders In Chronic Disease Management

FAX: 1-855-322-2087
PHONE: 1-855-443-9944
NPI: 1417216128

Deliver Medications To: ☐ Patient's Home ☐ Doctor's Office Date Needed By: _____ Pharmacy to arrange injection training? ☐Y ☐N

PATIENT DEMOGRAPHICS

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Prescription Insurance: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD

PATIENT CLINICAL INFORMATION/HISTORY: (PLEASE ATTACH A COPY OF PATIENT'S RECENT CHART NOTES, PATHOLOGY AND LABS)

Diagnosis: _____ ICD-10: _____ Severity: ☐ Moderate ☐ Severe Patient's Weight: _____ Sex: ☐ M ☐ F

TB Test: ☐ Yes ☐ No Result: _____ Date: _____ Does patient have active/serious infection: ☐ Yes ☐ No

_____% BSA AFFECTED BY PSORIASIS _____ # OF JOINTS AFFECTED Drug Allergies: _____

PATIENT SUPPORT AND INJECTION TRAINING AUTHORIZATION

I authorize Encompass Rx to enroll patient in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. Patient further authorizes Encompass to release and communicate to corresponding manufacturer the minimum necessary information about their health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, contact me occasionally for market research purposes and provide educational information regarding disease states. I understand patient may revoke this authorization at anytime in writing by sending a letter to Encompass Rx 2700 Northeast Expy NE, STE B-800, Atlanta, GA 30345. I understand that patient may refuse authorization and that refusal will not affect patient ability to obtain treatment from the pharmacy.

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Cosentyx	☐ 150mg Sensoready Pen ☐ 150mg PFS	☐ *Induction Dose:* Inject 300mg sc weekly for 5 weeks ☐ *Maintenance Dose:* Inject 300mg sc every 4 weeks	10	0
☐ Dupixent	☐ 300mg PFS	☐ *Induction Dose:* Inject 600mg sc on day 1, then 300mg sc every other week ☐ *Maintenance Dose:* **Inject 300mg sc every other week**	4	
☐ Enbrel	☐ 50mg/ml Sureclick ☐ 50mg/ml PFS ☐ 25mg/ml ☐ **50mg Mini**	☐ *Psoriasis Induction Dose:* Inject 50mg sc TWICE A WEEK (72-96 hrs apart) for 3 months ☐ *Maintenance Dose:* Inject 50mg sc once a week ☐ *Other:* _____	6 boxes	0
☐ Humira	☐ Psoriasis Starter Pack ☐ 40mg Pen ☐ 40mg PFS	☐ PHARMACY TO WARM TRANSFER THE PATIENT TO HUMIRA COMPLETE ☐ *Induction Dose:* Inject 80mg sc on day 1, 40mg on day 8, then maintenance dose ☐ *Maintenance Dose:* Inject 40mg sc every other week ☐ *Other:* _____	1 pack	0
☐ Humira	☐ Hidradenitis Suppurativa ☐ 40mg Pen ☐ 40mg PFS	☐ PHARMACY TO WARM TRANSFER THE PATIENT TO HUMIRA COMPLETE ☐ *Induction Dose:* Inject 160mg sc on day 1, then 80mg sc on day 15 ☐ *Maintenance Dose:* Inject 40mg sc on day 29, then 40mg sc every week	1 pack	0
☐ Orencia	☐ 125mg PFS ☐ 125mg ClickJet	☐ Inject 125mg subcutaneously ONCE a week		
☐ Otezla	☐ Titration Starter Pack ☐ 30mg Tablet	*Use Titration Starter Pack as directed* ☐ *Maintenance Dose:* Take one 30mg tablet orally twice daily ☐ *Bridge Dose:* Take one 30mg tablet orally twice daily Starter Pack Provided Date: _____	1 pack	0
☐ Siliq	☐ 210mg PFS	☐ *Induction Dose:* Inject 210mg sc at weeks 0,1,2, and 4 ☐ *Maintenance Dose:* Inject 210mg sc every 2 weeks	4	0
☐ Simponi	☐ 50mg Autoinjector ☐ 50mg PFS	☐ Inject 50mg sc once a month		
☐ Stelara	☐ 45mg PFS ☐ 90mg PFS	☐ *Induction Dose:* Inject 1 syringe sc on day 1, then 1 syringe sc on day 28 ☐ *Maintenance Dose:* Inject 1 syringe sc every 12 weeks	2 PFS	0
☐ Taltz	☐ 80mg Autoinjector ☐ 80mg PFS	☐ *Induction Dose:* Inject 160mg sc at Week 0, 80mg sc every 2 weeks until week 12 ☐ *Maintenance Dose:* Inject 80mg sc every 4 weeks	8	0
☐ Tremfya	☐ 100mg PFS	☐ *Induction Dose:* Inject 100mg sc on day 1 and 28 ☐ *Maintenance Dose:* Inject 100mg sc every 8 weeks	2 PFS	0

PRESCRIBER INFORMATION

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: Office Fax: Office Contact:

DEA: NPI: UPIN:

Signature: Date:

"By signing I hereby authorize Encompass Rx, LLC and its pharmacists, technicians and other employees and agents to disclose, share and submit patient information to health insurers, HMOs, employer group health plans, governmental health programs, or other payors, for the purposes of satisfying such payor's prior authorization requirements with respect to the medication being prescribed for the treatment of our mutual patient."