CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 800-237-2767

# Dermatology Enrollment Form

Date: _____ Needs by Date: _____

CarePlus™ CVS/pharmacy®

**Ship to:** ☐ **Patient** ☐ **Office** ☐ **Other:** _____

## PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

## PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

## INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

**Prescription Card:** Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
**Primary Insurance:** Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
**Secondary Insurance:** Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

## STATEMENT OF MEDICAL NECESSITY

**Diagnosis:**

☐ 696.1 Psoriasis ☐ 696.0 Psoriatic Arthritis ☐ Other: _____
• Date of Diagnosis: _____ OR Years With Disease _____

**Medical Assessment (Within Last 12 Months):**

• Psoriasis Severity: ☐ Moderate ☐ Moderate to Severe ☐ Severe
• Psoriasis Type: ☐ Plaque ☐ Other (please specify): _____

**Patient Evaluation:**

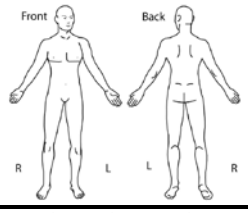
• Has Patient been diagnosed with Heart Failure? ☐ Yes ☐ No
• Has patient been diagnosed with Lymphoma? ☐ Yes ☐ No
• Does patient have serious/active infection? ☐ Yes ☐ No
• Has TB test been performed? ☐ Yes ☐ No
If yes, results: _____ Comments: _____
• Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No
If No, has treatment been initiated? ☐ Yes ☐ No
• Does patient have a latex allergy? ☐ Yes ☐ No
• Is patient's platelet count >52,000 cells/uL? ☐ Yes ☐ No
• Patient Weight: _____kg/lbs
• Allergies: _____ ☐ NKDA

**Prior (FAILED) Medications:**

| | *Medication* | *Reason for Discontinuation* |
|---|---|---|
| ☐ Biologics: | _____ | _____ |
| ☐ Methotrexate | N/A | _____ |
| ☐ Oral Meds: | _____ | _____ |
| ☐ PUVA | N/A | _____ |
| ☐ UVB | N/A | _____ |
| ☐ Topicals: | _____ | _____ |
| ☐ Other: | _____ | _____ |

**Patient Evaluation Cont.**

• _____BSA % affected by Psoriasis




**Injection training/Home Health Coordination:**

• Specialty Pharmacy to coordinate injection training/ home health nurse visit as necessary. ☐Yes ☐No
*Agency of choice: _____
• Injection training is not necessary.
Date training occurred: _____
Reason: ☐Referred by MD office to alternate trainer
☐Patient already independent ☐MD office trained patient

*Ancillary Supplies and Kits Provided As Needed for Administration*

## PRESCRIPTION INFORMATION *(Please choose induction and maintenance dose)*

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Enbrel® | ☐ 50mg/ml Sureclick™ Autoinjector<br>☐ 50mg/ml Prefilled Syringe<br>☐ 25mg/0.5ml Prefilled Syringe<br>☐ 25mg Vial | ☐ Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing.<br>☐ Psoriasis Maintenance Dose: Inject 50mg SC ONCE a week.<br>☐ Psoriatic Arthritis Dose: Inject 50mg SC ONCE a week.<br>☐ Other: _____ | | |
| ☐ Humira® | ☐ Psoriasis Starter Package<br>☐ 40mg/0.8ml Pen<br>☐ 40mg/0.8ml Prefilled Syringe | ☐ Psoriasis Induction Dose: Inject two 40mg pens/syringes SC on day 1, then one 40mg pen/syringe on day 8, then one 40mg pen every other week.<br>☐ Psoriasis Maintenance Dose: Inject one 40mg pen/syringe SC every other week.<br>☐ Psoriatic Arthritis Dose: Inject one 40mg pen/syringe SC every other week.<br>☐ Other: _____ | 1 | 0 |
| ☐ Remicade® | 100mg Vial | ☐ Induction Dose: Infuse 5mg/kg in 250mL of 0.9% NaCl at week 0, week 2, week 6, and every 8 weeks thereafter.<br>☐ Maintenance Dose: Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 weeks.<br>☐ Other: _____ | | |
| ☐ Simponi™ | ☐50mg/0.5ml SmartJect™ Autoinjector<br>☐50mg/0.5ml Prefilled Syringe | ☐ Psoriatic Arthritis Dose: Inject 50 mg (0.5ml) subcutaneously once a month<br>☐ Other: _____ | | |
| ☐ Stelara™ | ☐ 45mg/0.5ml prefilled syringe<br>☐ 90mg/mL prefilled syringe | ☐ For patients weighing < 100kg (220lbs): Inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks.<br>☐ For patients weighing > 100kg (220lbs): Inject 90mg SC initially and 4 weeks later, followed by 90mg every 12 weeks. | | |
| ☐ | | | | |

**Patient Support Programs:** I authorize CVS Caremark to enroll me 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. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my 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 and provide educational information regarding therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to CVS Caremark, Privacy Office, PO Box 659629, San Antonio, TX 78265-9529. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original. ☐ Enliven (*Enbrel*®) ☐ myHUMIRA®

• **Patient Signature** *(required for participation)*_____ Date: _____ ☐ AccessOne℠ (*Remicade*®) ☐ SimponiOne ☐STELARA™SUPPORT

**X** _____ PRODUCT SUBSTITUTION PERMITTED (Date)

**X** _____ DISPENSE AS WRITTEN (Date)