

1 PATIENT INFORMATION		2 ENROLLMENT CHECKLIST	
Written Date: _____ Need By Date: _____  Ship To: Patient (All Fills) Provider (1st Fill Only) Provider (All Fills) Other: _____	Patient Name: _____ Date of Birth: _____ SSN: _____ Address: _____ City, State, Zip Code: _____ Phone: _____ Email Address: _____ Preferred Language: _____ Contact Person: _____	Demographics Insurance Cards Last 2 visit notes TB Test Results (i.e. Quantiferon Gold or PPD; **only if rx for Biologic agents)	Documentation of disease severity (i.e. moderate, severe, etc.) % BSA affected Current medication list Prior treatment history
3 SPECIAL INSTRUCTION			
Training:		Pharmacy will coordinate training for patient Provider will provide training Training not necessary	Delivery: _____ _____

4 DIAGNOSIS AND CLINICAL INFORMATION			
Diagnosis (ICD-10): _____ Date of Diagnosis: _____  L40.0 Psoriasis vulgaris/Plaque psoriasis/Nummular Psoriasis L40.9 Psoriasis, unspecified L40.52 Psoriatic arthritis L40.5 Psoriasis, other	L30.0 Nummular dermatitis L73.2 Hidradenitis Suppurativa C48.A3 Primary cutaneous T-cell lymphoma L20 Atopic dermatitis L20.9 Atopic dermatitis, unspecified	<b>Has patient had positive TB test?</b> YES NO If yes, date of chest x-ray: _____  Height: _____ Weight: _____ Allergies: _____	<b>BSA affected (%):</b> _____ <b>Severity:</b> Moderate Moderate - Severe Severe  <b>Areas affected:</b> Palms Soles Head Neck Genitalia
Previously Tried/Failed Medications - Include dosage & frequency	Date of Trial	Reason for Discontinuation	

5 PRESCRIPTION INFORMATION			
MEDICATION	STRENGTH/FORMULATION	DIRECTIONS	QUANTITY/REFILLS
<b>Enbrel®</b>	50mg/mL Prefilled Syringe 50mg/mL SureClick Autoinjector	Psoriatic Arthritis: Inject 50mg SQ once weekly Plaque Psoriasis: INDUCTION & MAINTENANCE: Inject 50mg SQ twice weekly x 3 months, then maintenance Plaque Psoriasis: MAINTENANCE ONLY: Inject 50mg SQ once weekly	3 months 6 months 1 year Other: _____
<b>Humira®</b>	Humira Psoriasis/Uveitis Starter Pack 40mg/0.8mL Prefilled Syringes 40mg/0.8mL Prefilled Pens	Hidradenitis suppurativa: INDUCTION & MAINTENANCE: Inject 160mg SQ (given in 1 day or split over 2 consecutive days), followed by 80mg SQ on day 15, and then 40mg SQ every week starting on day 29) Hidradenitis suppurativa: MAINTENANCE ONLY: Inject 40mg SQ every week Plaque Psoriasis: INDUCTION & MAINTENANCE: Inject 80mg SQ once, followed by 40mg SQ every other week starting 1 week after the initial dose Plaque Psoriasis: MAINTENANCE ONLY: Inject 40mg SQ every other week Psoriatic arthritis: Inject 40mg SQ every other week	3 months 6 months 1 year Other: _____
<b>Simponi®</b>	50mg/0.5mL Prefilled Syringe 50mg/0.5mL Prefilled SmartJect Autoinjector	Inject 50mg SQ once monthly	3 months 6 months 1 year Other: _____
<b>Stelara®</b>	45mg/0.5mL Prefilled Syringes 90mg/mL Prefilled Syringes	<100kg: Plaque Psoriasis: INDUCTION & MAINTENANCE: Inject 45mg SQ initially & 4 weeks later, then 45mg SQ every 12 weeks <100kg: Plaque Psoriasis: MAINTENANCE ONLY: Inject 45mg SQ every 12 weeks >100kg: Plaque Psoriasis: INDUCTION & MAINTENANCE: Inject 90mg SQ initially & 4 weeks later, then maintenance >100kg: Plaque Psoriasis: MAINTENANCE ONLY: Inject 90mg SQ every 12 weeks Psoriatic Arthritis: INDUCTION & MAINTENANCE: Inject 45mg SQ initially & 4 weeks later, then 45mg SQ every 12 weeks Psoriatic Arthritis: MAINTENANCE ONLY: Inject 45mg SQ every 12 weeks	3 months 6 months 1 year Other: _____
<b>Cimzia®</b>	Cimzia Starter Kit 200mg/mL Prefilled Syringe 200mg Vial	INDUCTION & MAINTENANCE: Inject 400mg SQ once, and then at weeks 2 and 4, and then 200mg SQ once every 2 weeks MAINTENANCE ONLY: Inject 200mg SQ once every 2 weeks OR INDUCTION & MAINTENANCE: Inject 400mg SQ once, and then at weeks 2 and 4, and then 400mg SQ once every 4 weeks MAINTENANCE ONLY: Inject 400mg SQ once every 4 weeks	3 months 6 months 1 year Other: _____
<b>Dupixent®</b>	300mg/2mL Prefilled syringes	INDUCTION & MAINTENANCE: inject 600mg SQ in 2 different injection sites, then 300mg SQ every other week MAINTENANCE ONLY: Inject 300mg SQ every other week	3 months 6 months 1 year Other: _____
<b>Taltz®</b>	80mg/mL Prefilled Autoinjector 80mg/mL Prefilled Syringe	INDUCTION & MAINTENANCE: Inject 160mg total SQ at week 0, followed by 80mg SQ at weeks 2, 4, 6, 8, 10, 12, then 80mg every 4 weeks MAINTENANCE ONLY: Inject 80mg SQ every 4 weeks	3 months 6 months 1 year Other: _____

6 PROVIDER AUTHORIZATION & INFORMATION			
By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and to execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.			
Prescriber Name: _____	Address: _____		
DEA: _____	NPI: _____	City, State, ZIP Code: _____	
Phone: _____	Fax: _____	Contact Person: _____	
Date: _____	Provider Signature: _____		Do not substitute