DolphinHealth Rx
Committed to Helping People Get Well

# Dermatology Oral & Topical Enrollment and RX Form

(Otezla®, Targretin®, Eucrisa™, Enstilar®)

Toll Free: 844-436-5744
Local Phone: 510-900-3131
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## 1 PATIENT INFORMATION

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:

## 2 ENROLLMENT CHECKLIST

- 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

**Has patient had positive TB test?**

- YES
- NO

If yes, date of chest x-ray: ____________

Height: ____________

Weight: ____________

Allergies: ____________

**BSA affected (%):** ____________

**Severity:**

- Moderate
- Moderate - Severe
- Severe

**Areas affected:**

- Palms
- Soles
- Head
- Neck
- Genitalia

| Previously Tried/Failed Medications - Include | Date of Trial | Reason for Discontinuation |
|---|---|---|
| | | |
| | | |
| | | |

## 5 PRESCRIPTION INFORMATION

| MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| **Otezla®** | 28-day Starter Pack<br>Maintenance | Titration + Maintenance:<br>Initial titration over 5 days:<br>Day 1: Take 10mg orally every morning<br>Day 2: Take 10mg orally twice daily<br>Day 3: Take 10mg orally every morning and 20mg orally every evening<br>Day 4: Take 20mg orally twice daily<br>Day 5: Take 20mg orally every morning and 30mg orally every evening<br>Maintenance: (Day 6 +): Take 30mg orally twice daily<br><br>Maintenance only: Take 30mg orally twice daily | 55 tablets (one 28-day pack)<br>60 tablets<br>Other: ________<br>Refills:<br>1 year OR<br>________ |
| **Targretin® Capsules**<br>Do Not Substitute | 75mg capsules | Take ________mg (300mg/m²/day x _______m²) once daily as single daily dose with a meal (BSA = ________; Dose = ________ OR Height: _________ & Weight: ________ )<br><br>Take ________mg (400mg/m²/day x ________m²) once daily as single daily dose with a meal (BSA = ________; Dose = ________OR Height: _________ & Weight: ________ )<br><br>Other: ________________________ | QS<br>________<br>Refills:<br>1 year OR<br>________ |
| **Targretin® Gel** | 1% gel (60 grams) | Apply topically to affected every other day for 1 week, then at weekly intervals increase to once daily, then twice daily, then three times daily & finally four times daily as tolerated<br><br>Other: ____________________ | ________ tubes<br>Refills:<br>1 year OR<br>________ |
| **Eucrisa™** | 2% ointment (60 grams) | Apply topically a thin layer to affected areas twice daily | ________ 60 gram tube<br>Refills:<br>1 year OR<br>________ |
| **Enstilar®** | 0.005-0.064% Foam (60 grams)<br>0.005-0.064% Foam (120 grams) | Apply topically to affected areas once daily for up to 4 weeks (max: 60g every 4 days) | ________ 60 gram can<br>________ 120 gram can<br>Refills:<br>1 year OR<br>________ |

## 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:

DEA:

NPI:

Phone:

Fax:

Date: ____________

Provider Signature: ____________

Address: ____________

City, State, ZIP Code: ____________

Contact Person: ____________

Do not substitute

5/2/2017