Sunray Specialty Pharmacy

Dermatology Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Alternate Phone: _____
DOB: _____
Last 4 Digits of SS#: _____
Gender: _____
Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
DEA: _____
NPI: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

BIN: _____ PCN: _____ Rx Group: _____ ID #: _____ Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

- ☐ L40.0 Psoriasis vulgaris
- ☐ L40.1 Generalized pustular psoriasis
- ☐ L40.2 Acrodermatitis continua
- ☐ L40.3 Pustulosis palmaris et plantaris
- ☐ L40.4 Guttate psoriasis
- ☐ L40.54 Psoriatic juvenile arthropathy
- ☐ L40.59 Other psoriatic arthropathy
- ☐ L40.8 Other psoriasis _____
- ☐ L73.2 Hidradenitis suppurativa

Other Diagnosis:
ICD-10 Code: _____
Description: _____

Additional information:

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Weight: _____ kg/lb Height _____ cm/in
Allergies: _____
Lab Data: _____
Prior Therapies: _____
Concomitant Medications: _____
_____
Injection Training Required: ☐ Yes ☐ No
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ Review Date _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Cimzia®	☐ 200 mg/mL Prefilled Syringe Starter Kit ☐ 200 mg/mL Prefilled Syringe ☐ 200 mg/mL Vial Kit			
Enbrel®	☐ 50 mg/mL SureClick Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ 25 mg/0.5 mL Prefilled Syringe ☐ 25 mg Vial ☐ Enbrel Mini 50 mg/mL Cartridge			
Humira®	☐ 40 mg/0.4 mL Prefilled Syringe ☐ 40 mg/0.8 mL Prefilled Syringe ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.8 mL Pen ☐ 80 mg/0.8 mL CD/UC/HS Starter Pack ☐ 40 mg/0.8 mL Pen CD/UC/HS Starter Pack ☐ 80 mg/0.8 mL & 40 mg/0.4 mL Pen PS/UV Starter Pack ☐ 40 mg/0.8 mL Pen PS/UV Starter Pack			
Otezla®	☐ 30 mg Tablet ☐ Starter Pack (28-day) ☐ Starter Pack (2-week)			
Remicade®	☐ 100 mg Vial			
Simponi®	☐ 50 mg/0.5 mL Prefilled Syringe ☐ 50 mg/0.5 mL SmartJect Autoinjector			
Simponi Aria®	☐ 50 mg/4 mL Vial			
Stelara®	☐ 45 mg/0.5 mL Vial ☐ 45 mg/0.5 mL Prefillleed Syringe ☐ 90 mg/mL Prefilled Syringe			
Taltz®	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe			
Tremfya®	☐ 100 mg/mL Prefilled Syringe			
Xeljanz®	☐ 5 mg Tablet			
Xeljanz XR®	☐ 11 mg ER Tablet			
OTHER: _____				

Please deliver to: ☐ Patient ☐ Office ☐ Other _____ by this date: _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: _____