Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Twin Oaks Specialty Pharmacy

Fax: 855-909-TOSP (8677)

Dermatology Enrollment Form

Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy? ☐

1: Patient Information | Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Patient Name: _____ **Birthdate:** _____ **Sex:** ☐ Male ☐ Female **Height:** _____ **Weight:** _____ ☐ lbs. ☐ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

2: Prescriber Information

☐ _____ ☐ _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____

Date of Diagnosis (or years with disease): _____

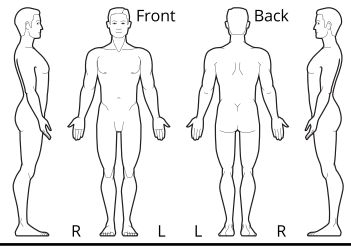
Has patient been treated previously for this condition? ☐ Yes ☐ No

If yes, medication/therapy failed (length of therapy): _____

Has Patient received PPD (tuberculosis) Skin Test? ☐ Yes ☐ No

Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No

Does patient have a latex allergy? ☐ Yes ☐ No



_____ % BSA affected by Psoriasis

4: Prescription Information

Medication	Dose/Strength	Sig & Qty	Refills
☐ **Cosentyx®**	☐ Sensoready Pen ☐ Pre-filled Syringe ☐ Vial	**Starter Dose:** ☐ Inject 300 mg SQ on weeks 0,1,2,3, and 4 (Qty 10) ☐ Inject 150 mg on weeks 0,1,2,3, and 4 (qty 10) **Maintenace Dose:** ☐ Inject 300 mg SC every 4 weeks (Qty 2) ☐ Inject 150 mg SQ every 4 weeks (Qty 2)	
☐ **Enbrel®**	☐ SureClick™ Pen ☐ Mini™ with Auto Touch™ ☐ Pre-filled Syringe 50mg ☐ Pre-filled Syringe 25mg	☐ **Induction Dose:** Inject 50mg SC TWICE a week *(72-96 hours apart for 3 months)* (Qty 8 RF-2) ☐ **Maintenance Therapy:** Inject 50mg SC ONCE a week (Qty 4) ☐ **Other:**	
☐ **Humira®**	☐ **Psoriasis** Starter Kit ☐ 40mg Pen ☐ 0.8ml ☐ 0.4ml ☐ 40mgPFS ☐ **HS** Starter Kit	☐ **Initial Dose:** Inject 80mg SC on Day 1, 40mg on day 8, then 40mg every other week (Qty 4) ☐ **Maintenance Therapy:** Inject 40mg SC every other week (starting 1 week after initial dose) (Qty 2) ☐ **HS Initial:** Inject 160mg SC on day 1 and 80 mg on day 15 (Qty 6) ☐ **HS Maintenace:** Inject 40mg SC every week beginning on day 29 (Qty 4)	
☐ **Stelara®**	☐ 45mg/0.5ml Pre-filled Syringe ☐ 90mg/1ml Pre-filled Syringe	**Starter Dose:** ☐ Inject 45mg SC **(patient <100 kg)** at Day 1 (Qty 1) ☐ Inject 90mg SC **(patient >100 kg)** at Day 1 (Qty 1) **Maintenance:** ☐ Inject 45mg SC **(patient <100 kg)** *29 days after starter dose and then every 12 weeks* (Qty 1) ☐ Inject 90mg SC **(patient >100 kg)** *29 days after starter dose and then every 12 weeks* (Qty 1) ☐ **Other:**	
☐ **Otezla®**	☐ 28 Day Starter Pak ☐ Maintenance	☐ 14 day titration stater pak sample provided by MD ☐ Take as directed per package instructions (Qty 55) ☐ Take 30mg once daily (Qty 30) ☐ Take 30mg twice daily (Qty 60) **Continuation of therapy**: ☐ YES ☐ NO	
☐ **Simponi®**	☐ SmartJect Pen ☐ Pre-filled Syringe	☐ Inject 50mg SC once a month (Qty 1)	
☐ **Tremfya®**	☐ Pre-filled Syringe	☐ **Initial:** Inject 100mg SC on week 0 and week 4 (Qty 1 plus 1 refill) ☐ **Maintenance:** Inject 100mg SC evey 8 weeks (Qty 1)	
☐ **Dupixent®**	☐ Pre-filled Syringe	☐ **Initial:** Inject 600mg (2 PFS in diff sites) SQ on day 1 (Qty 2) ☐ **Maintenance:** Inject 300mg SQ every other week starting at day 15 (Qty 2)	
☐ **Taltz®**	☐ Auto injector ☐ Pre-filled Syringe	☐ **Starting:** Inject 160mg SC on week 0 (Qty 1) ☐ **Induction:** Inject 80mg SC every 2 weeks (weeks 2-12) (Qty 2 plus 2 refills) ☐ **Maintenance:** Inject 80mg SC every 4 weeks after 12 weeks (Qty 1)	
☐ **Siliq®**	☐ Pre-filled Syringe	☐ **Initial:** Inject 210 mg SC on weeks 0 and 1 (Qty 2) ☐ **Maintenance:** Inject 210 mg SC every 2 weeks starting on week 2 (Qty 2)	

Patient: By signing this form, patient agrees to release his/her PHI to Twin Oaks Specialty Pharmacy for the purpose of medical and pharmaceutical treatment as per HIPAA compliance and to enroll in the pharmaceutical company assisted patient support programs. **Patient Signature:** **Date:**

Prescriber Signature: By signing this form, and utilizing our services, you are also authorizing Twin Oak Specialty Pharmacy to serve as your designated agent in dealing with medical and prescription insurance companies and co-pay assistance foundations.

Dispense as written Date Substitution Permissable **Date:**