Specialty Pharmacy Services Enrollment Form

Phone: (844) 431-7277

Fax: (844) 432-7277

New York Prescribers, please submit an electronic prescription together with the Enrollment Form

Dermatology

For pharmacy locations, please scan QR code

PATIENT INFORMATION

Patient's Name:	Last 4 Digits of SS#:	DOB:	Sex: ○ M ○ F	Weight:	Height:	Diabetic: ○ Y ○ N
Address:		Allergies:				
City:	State:	Zip:	Home Phone:	Work or Cell: ( )		
HIPAA Contact:	Emergency #:		Interpreter Needed: ○ Y ○ N			

PRESCRIBER INFORMATION

Prescriber Name:	○ MD ○ DO ○ NP ○ PA	NPI:	
Office Contact:	Supervising Physician, if applicable:		
Address:	City:	State: NY	Zip:
Phone:	Fax:		

INSURANCE INFORMATION | PLEASE INCLUDE THE FOLLOWING INSURANCE INFORMATION - OR - COPY OF INSURANCE CARD ATTACHED ☐

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

CLINICAL INFORMATION | PLEASE SEND COPY OF PROGRESS NOTES AND LAB REPORTS SUPPORTING DIAGNOSIS

ICD- ICD-10/Diagnosis Code:	○ Psoriasis Vulgaris (L40.0) ○ Other Psoriasis (L40.8) ○ Psoriasis Unspecified (L40.9) ○ Psoriatic Arthritus (L40.5) ○ HidradenitisSuppurativa (L73.2) ○ Other:			
TB/PDD Test Given? ○ Y ○ N	Date of Neg. Test:	HBV Positive? ○ Y ○ N	If yes, patient currently treated? ○ Y ○ N	Prior Treatment? ○ Y ○ N (provide Information below)
BSA affected (%):	Affected Areas: ○ Palms ○ Soles ○ Head ○ Neck ○ Genitalia ○ Other:			

Prior Therapy:	Reason for Discontinuation of Therapy:	Approximate Start Date:	Approximate End Date:
Comorbidities:	Concomitant Medications:	Allergies: ○ NKDA ○ Other:	

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Quantity	Refills
○ COSENTYX® ○ PFS ○ Sensoready Pen	○ 4 cartons (8x150mg/ml) ○ 2 cartons (4x150mg/ml) ○ 1 cartons (2x150mg/ml) ○ 1 cartons (1x150mg/ml)	○ Starter Dose: Inject 300mg SQ at weeks 0,1,2,3 ○ Starter Dose: Inject 150mg SQ at weeks 0,1,2,3 ○ Maintenance Dose: Inject 300mg SQ every 4 weeks beginning on Day 29 ○ Maintenance Dose: Inject 150mg SQ every 4 weeks beginning on Day 29	28 Day Supply	
○ DUPIXENT® ○ PFS (with needle shield) ○ PFS (without needle shield)	○ 1 carton (2x300mg/2ml)	○ Starter Dose: Inject 600mg SQ at week 0. Begin Maintenance Dose at week 2 ○ Maintenance Dose: Inject 300mg SQ every 2 weeks	28 Day Supply	
○ ENBREL® ○ SureClick® ○ PFS	○ 1 carton (4x50mg/ml) ○ 2 cartons (4x50mg/ml)	○ Starter Dose: Inject 50mg Sub-Q twice a week (72-96 hours apart) x 3 months ○ Maintenance Dose: Inject 50mg Sub-Q every week	28 Day Supply	
○ HUMIRA® (Plaque Psoriasis) ○ Pens ○ Vials ○ PFS	○ Starter Kit (4x40mg/0.8ml) Pens ○ 1 carton (2x40mg/0.8ml) ○ 2 carton (2x40mg/0.8ml)	○ Starter Dose: Inject 80mg SQ Day 1, then 40mg on day 8, then 40mg every 2 weeks ○ Maintenance Dose: 40mg SQ every 2 weeks	28 Day Supply	
○ HUMIRA® Hidradenitis Suppurativa) ○ Pens ○ Vials	○ Starter Kit (6x40mg/0.8ml) 2 cartons (2x40mg/0.8ml)	○ Starter Dose: Inject 160mg SQ Day 1 (or 80mg SQ on Day 1 and Day 2); then 80mg on Day 15 Maintenance Dose: Starting on Day 29, 40mg SQ every week	28 Day Supply	
○ OTEZLA®	○ 55 tablets (One 28-day pack) 60 tablets	○ Starter Dose: Take as directed per package instructions Maintenance Dose: Take 30mg twice daily by mouth	28 Day Supply	
○ TREMFYA	○ 1 PFS	○ Starter dose: Inject 100mg Sub-Q at week 0, week 4, and every 8 weeks thereafter ○ Maintenance dose: Inject 100mg Sub-Q every 8 weeks	28 Day Supply	
○ STELARA® Patient eligible for self-injection ○ Yes ○ No	○ 1 PFS	○ Starter Dose: Inject 45mg/0.5mL Sub-Q on Day 1 (≤100kg) ○ Inject 90mg/1 mL Sub-Q on Day 1 (>100kg) ○ MaintenanceDose: Inject 45mg/0.5mL Sub-Q on Day 29 and every 12 weeks thereafter (≤100kg) ○ Inject 90mg/1 mL Sub-Q on Day 29 and every 12 weeks thereafter (>100kg)	28 Day Supply	
○ Other				
Needs by Date:	Additional Information			

Injection Training

○ Patient received injection training ○ Prescriber's office to provide injection training ○ Price Chopper Specialty to coordinate injection training

By signing this form and utilizing our services, you are authorizing Price Chopper Specialty to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: Date Issued: / /	Prescriber Signature: Date Issued: / /
Substitution Permitted	Dispense as Written

Interchange is mandated unless the practitioner indicates 'Dispense as Written' or 'No Substitution' in accordance with the law.