Carepoint™
A Pharmacy That Truly Cares

Dermatology Enrollment Form

P: (855) 237-9112 | F: (855) 237-9113 | www.carepointrx.com

Thank You For Trusting Us With Your Patients Care.

PATIENT

PLEASE INCLUDE FACE SHEET & ALL INSURANCE CARDS

Name _____ DOB _____ Phone _____

Address _____ City, State _____ Zip _____

MEDICAL ASSESSMENT

DATE _____ Height & Weight: _____ Allergies: _____

DIAGNOSIS: ☐ L40.0 Psoriasis ☐ Other: _____

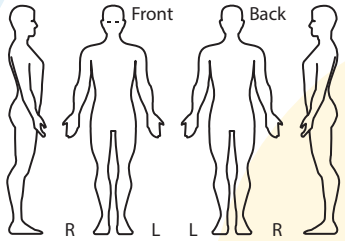
TB/PPD Test? Result: _____ History of Cancer? ☐ Yes ☐ No

Secondary infection? _____

Current Medications: _____

_____

_____



_____ % BSA affected by Psoriasis

Prior Therapies:	Reason for Discontinuation:	Appx. Start Date:	Appx. End Date:

PRESCRIPTION

			Days supply/Refills:
Cosentyx®:	☐ 150mg/ml pen ☐ 150mg/ml prefilled syringe	☐ Initial Dose: Inject ____mg subcutaneously at week 0, 1, 2, 3 and 4 ☐ Maintenance: Inject ____mg subcutaneously once every 4 weeks	4 weeks /_____ 4 weeks /_____
Enbrel®:	☐ 50mg SureClick ☐ 50mg syringe	☐ Initial Dose: Inject 50 mg subcutaneously twice weekly for 12 weeks ☐ Maintenance: Inject 50 mg once weekly	4 weeks /_____ 4 weeks /_____
Humira®:	☐ Starter Pack *(Adult >88 lbs)* ☐ 40mg prefilled syringe ☐ 40mg pen	☐ Inject 80 mg subcutaneously on day 0, 40 mg on day 7 then 40 mg every other week thereafter Inject 40 mg SC once: ☐ WEEKLY ☐ EVERY OTHER WEEK	4 weeks /_____ 4 weeks /_____
Otezla®:	☐ Starter Pack ☐ Maintenance Pack (30 mg)	☐ Take as directed per package instructions (6-day titration) ☐ Take 30 mg by mouth twice daily	1 pack /_____ 1 month /_____
Stelara®:	☐ 45 mg prefilled syringe (<220 lbs.) ☐ 90 mg prefilled syringe (>220 lbs.)	☐ Inject_____ mg subcutaneously on day 0 ☐ Inject_____ mg subcutaneously at week 4, then every 12 weeks	4 weeks /_____
OTHER:	☐ Drug: _____ ☐ Drug: _____	☐ Sig: _____ ☐ Sig: _____	_____ /_____ _____ /_____

☒ Dispense sufficient quantity of all necessary supplies (syringes, needles, alcohol wipes, etc.) for medication administration

PROVIDER

PLEASE INCLUDE ALL RECENT LABS & CLINICAL NOTES

Prescriber Name _____ Phone _____ Fax _____

_____ (_____) _____

Prescriber Signature ***NPI or DEA*** ***In-Office Contact Person***

**By Signing this form and utilizing our services, you are authorizing Carepoint and it's employees to serve as your designated agent for handling*