ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY
www.acropharmacy.com
Sharon Hill, PA
Phone: 800.906.7798
Fax: 877.381.3806
NCPDP: 3982902
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Memphis, TN
Phone: 800.906.7798
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NCPDP: 4447783
NPI: 1518349562

DERMASSIST®
ENROLLMENT FORM (A-M)

Today's Date:_____
Needed By:_____

Last update 12.04.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY
www.commcarepharmacy.com
Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: ☐Hidradenitis Suppurativa (L73.2) ☐Plaque Vulgaris (L40.0) ☐Psoriasis (L40.9) ☐Atopic dermatitis (L20.9) ☐Other_____
Psoriasis Type:_____ Date of Diagnosis: _____ Severity of Psoriasis: ☐Mild ☐Moderate ☐Severe

Injection Training: ☐Patient has received injection training ☐Physician's office to provide injection training ☐Specialty Pharmacy to coordinate injection training

Requested Clinical Information: *(as applicable)*
Does patient have a latex allergy? □Yes □No
Has Hepatitis B been ruled out? □Yes □No
Does patient have serious/active infection? □Yes □No
Has TB test been performed? □Yes □No
If Yes, Results _____

Previous Therapies:
_____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐**Cosentyx**®	☐150mg/mL Sensoready® Pen ☐150mg/mL Prefilled Syringe ☐150mg Single Use Vial	☐**INITIAL:** Inject 300mg SQ initially (Weeks 0, 1, 2, 3, & 4) then maintenance ☐**MAINTENANCE:** Inject 300mg SQ every 4 weeks ☐Other_____	☐**INITIAL:** 35 day supply ☐**MAINTENANCE:** 4 weeks ☐Other_____	
☐**Dupixent**®	☐300mg/2mL Prefilled Syringe	☐**INITIAL:** Inject 600mg SQ initially, followed by 300mg SQ every other week ☐**MAINTENANCE:** Inject 300mg SQ every other week ☐Other_____	☐**INITIAL:** 14 day supply, no refills ☐**MAINTENANCE:** 4 weeks ☐Other_____	
☐**Enbrel**®	☐50mg/mL Sureclick Pen ☐50mg/mL Prefilled Syringe ☐25mg/0.5mL Prefilled Syringe ☐25mg Multiple Use Vial ☐Mini 50mg/mL Cartridge	☐**INITIAL:** Inject 50mg SQ twice every week (3-4 days apart) for 3 months then maintenance ☐**MAINTENANCE:** Inject 50mg SQ ONCE a week ☐Other_____	☐**INITIAL:** 3 month supply ☐**MAINTENANCE:** 4 weeks ☐Other_____	
☐**Humira**®	***Hidradenitis Suppurativa*** ***Citrate Free Starter Kit*** ☐80mg/0.8mL CD PEDIATRIC #3 PFS ☐80mg/0.8mL+40mg/0.4mL CD PEDIATRIC #2 PFS ☐80mg/0.8mL CD/UC/HS #3 PEN ***Citrate Free Maintenance Kit*** ☐10mg/0.1mL PFS ☐20mg/0.2mL PFS ☐40mg/0.4mL PEN ☐40mg/0.4mL PFS ***Non-Citrate Free Starter Kit*** ☐40mg/0.8mL CD/UC/HS PEDIATRIC #6 PFS ☐40mg/0.8mL CD/UC/HS PEDIATRIC #3 PFS ☐40mg/0.8mL CD/UC/HS #6 PEN ***Non-Citrate Free Maintenance Kit*** ☐10mg/0.2mL PFS ☐20mg/0.4mL PFS ☐40mg/0.8mL PEN ☐40mg/0.8mL PFS	***Adult*** ☐**INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 15, then ONCE weekly maintenance on day 29 ***Child ≥12 years: 30kg (66lbs) to <60kg (132lbs)*** ☐**INITIAL:** Inject 80mg SQ on day 1, then 40mg on day 8, then 40mg EVERY OTHER week ***Child ≥12 years: ≥ 60kg (132 lbs)*** ☐**INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 15, then ONCE weekly maintenance on day 29 ☐**MAINTENANCE:** Inject 40mg SQ ONCE weekly ☐**MAINTENANCE:** Inject 40mg SQ every other week ☐Other_____	☐**INITIAL:** Starter kit ☐**MAINTENANCE:** 4 weeks ☐Other_____	
	Psoriasis ***Citrate Free Starter Kit*** ☐80mg/0.8mL+40mg/0.4mL PS/UV #3 PEN ***Citrate Free Maintenance Kit*** ☐40mg/0.4mL PEN ☐40mg/0.4mL PFS ***Non-Citrate Free Starter Kit*** ☐40mg/0.8mL Starter Kit PS/UV #4 PEN ***Non-Citrate Free Maintenance Kit*** ☐40mg/0.8mL PEN ☐40mg/0.8mL PFS	☐**INITIAL:** Inject 80mg SQ on day 1, then 40mg on day 8, then maintenance ☐**MAINTENANCE:** Inject 40mg SQ every other week ☐Other_____	☐**INITIAL:** Starter kit ☐**MAINTENANCE:** 4 weeks ☐Other_____ **PFS = prefilled syringe, PEN = prefilled pen, CD = Crohn's Disease, UC = Ulcerative Colitis, HS = Hidradenitis Suppurative, PS = Psoriasis, UV = Uveitis, SQ = subcutaneously**	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ ☐DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.
***Patient Signature:** (required for participation)_____ Date:_____ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program