ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY
www.acropharmacy.com

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DERMASSIST®
ENROLLMENT FORM (N-Z)

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
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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
☐**Otezla®**	☐Titration Starter Pack ☐30mg Tablet	☐**INITIAL:** Take as directed x28 days (Blister Titration Pack) ☐**MAINTENANCE:** 30mg tablet orally twice daily ☐Other_____	☐**INITIAL:** 1 Starter Pack ☐**MAINTENANCE:** 4 week supply ☐Other_____	
☐**Siliq™**	☐210mg/1.5mL Prefilled Syringe	☐**INITIAL:** Inject 210mg SQ at weeks 0, 1, 2, then every 2 weeks ☐**MAINTENANCE:** Inject 210mg SQ every 2 weeks ☐Other_____	☐**INITIAL:** 4 week supply ☐**MAINTENANCE:** 4 week supply ☐Other_____	
☐**Simponi®**	☐50mg /0.5mL Autoinjector ☐50mg /0.5mL Prefilled Syringe	☐Inject 50mg SQ ONCE a month ☐Other_____	☐**MAINTENANCE:** 4 week supply ☐Other_____	
☐**Stelara®**	☐45mg/0.5mL Prefilled Syringe ☐45mg/0.5mL Single Use Vial ☐90mg/1 mL Prefilled Syringe	*Patients with weight ≤ 100kg* ☐**INITIAL:** Inject 45 mg SQ initially (week 0) & 4 weeks later ☐**MAINTENANCE:** Inject 45 mg SQ every 12 weeks *Patients with weight > 100kg* ☐**INITIAL:** Inject 90 mg SQ initially (week 0) & 4 weeks later ☐**MAINTENANCE:** Inject 90 mg SQ every 12 weeks	☐**INITIAL:** # _____syringe/vial ☐**MAINTENANCE:** 12 week supply ☐Other_____	
☐**Taltz®**	☐80 mg/1 mL Autoinjector ☐80 mg/1 mL Prefilled Syringe	***Moderate to Severe Psoriasis: With or without Active Psoriatic Arthritis*** ☐**INITIAL:** Inject 160mg (2 x 80mg) SQ on day 1, then begin first induction dose (1 x 80mg) 2 weeks later (week 2) ☐**INDUCTION:** Inject 1 x 80mg SQ every 2 weeks (weeks 4-10) ☐**FINAL INDUCTION:** Inject 1 x 80mg SQ (week 12) ☐**MAINTENANCE:** Inject 1 x 80mg SQ every 4 weeks	**INITIAL:** 3 pens/syringes **INDUCTION:** 2 pens/syringes **FINAL INDUCTION:** 1 pen/syringes **MAINTENANCE:** 1 pen/syringes	**0** **1** **0**
☐**Tremfya®**	☐100 mg/1 mL Prefilled Syringe	☐**INITIAL:** Inject 100 mg SQ initially (week 0) & 4 weeks later ☐**MAINTENANCE:** Inject 100 mg SQ every 8 weeks	**INITIAL:** 2 syringes, no refills **MAINTENANCE:** ☐8 week supply ☐Other_____	
☐**Other**			**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