North Texas Infusion Specialty Pharmacy and Infusion Centers

3409 Worth St. #710 Dallas, TX 75246 (214) 823-2533 FAX (214) 887-0436 www.NTISP.org

Dermatology Enrollment Form

Patient Information:
Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Alt. Phone:_____
SS#:_____
DOB:_____ Gender:_____

Physician Information:
Physician Name:_____
Address:_____
City, State, Zip:_____
Phone #:_____
Fax #:_____
Contact Person:_____
DEA#:_____

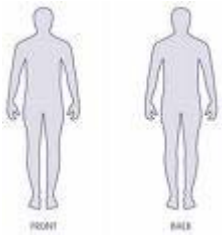
Primary Insurance Information
Insurance Name
Cardholder Name
Group/Policy #
Group #

Secondary Insurance Information
Insurance Name
Cardholder Name
Group/Policy#

Pharmacy Insurance Information
Insurance Name
Member ID
BIN Number

Statement of Medical Necessity

Diagnosis:
☐ 696.1 Psoriasis ☐ 696.0 Psoriatic Arthritis ☐ Other_____ * _____BSA% affected by Psoriasis
Date of DX:_____



Patient Evaluation:
*Has patient been diagnosed with heart failure? ☐yes ☐no
*Has patient been diagnosed with Lymphoma? ☐yes ☐no
*Does patient have serious/active infection? ☐yes ☐no
*Has TB test been performed? ☐yes ☐no
If yes, results:_____ Comments:_____
*Has Hepatitis B been ruled out or treatment been initiated? ☐yes ☐no
*Does patient have a latex allergy? ☐yes ☐no
*Is patient's platelet count >52,000 cells/uL? ☐yes ☐no
*Patients weight:_____ *Patients height:_____

Medical Assessment (Within Last 12 Months)
*Allergies:_____ ☐NKDA

Psoriasis Severity ☐Moderate ☐Moderate to Severe ☐Severe
Psoriasis Type ☐Plaque ☐Other(specify)_____

Prior (Failed) Medications:	Medication	Reason for Discontinuation
☐ Biologics	_____	_____
☐Methotrexate	N/A	_____
☐Oral Meds	_____	_____
☐PUVA	N/A	_____
☐UVB	N/A	_____
☐Topicals	_____	_____
☐Other	_____	_____

Prescription Information: (Please choose induction & maintenance dose)

Medication	Strength	Directions	Quantity	Refill
Enbrel	☐50mg/ml Sureclick ☐50mg/ml Prefill Syringe ☐25mg/0.5ml Prefill Syringe ☐25mg Vial	☐Inject 50mg SQ twice a week (3-4)days apart for 3 months then maintenance dosing. ☐Psoriasis Maint. Dose:Inject 50 mg SQ once a week ☐Psoriatic Arthritis Dose:Inject 50 mg SQ once a week. ☐Other		
Humira	☐Psoriasis Starter Package ☐ 40mg/0.8ml Pen ☐40mg/0.8ml Prefill Syringe	☐Inject 40mg pen/syringe SQ daily ,then one 40mg pen/syringe on day 8 then one 40mg pen every other week. ☐Maintenance Dose-Inject one 40mg pen/syringe SQ every other week. ☐Arthritis Dose-Inject one 40mg pen/syringe SQ every other week ☐ Other:_____		
Remicade	100mg Vial	☐Induction Dose-Infuse 5mg/kg in 250ml of 0.9% NaCl week 0, week 2, week 6, week 8 ☐Maintenance Dose-Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 weeks ☐Other:_____		
Stelara	45mg/0.5ml single-use glass vial	☐Patients weighing <100kg(200lbs) Inject 45mg SQ initially & 4 weeks later, followed by 45mg every 12 weeks. ☐Patients weighing >100kg(220lbs) Inject 90 mg (two 45mg vials)SQ initially & 4 weeks later, followed by 90mg every 12 weeks.		
Other				

_____
Physician Signature **Date**

Fax completed form to (214) 887-0436. Insurance / Clearance Questions call (214)-276-5642 or e-mail mike.ellis@ntisp.org. Pharmacy / Clinical questions (214)-276-5623 Please include the following when faxing form: Copy of insurance card(s) front & back, Pharmacy Benefit Card, lab work, letter of medical necessity, and any other supporting documentation for the drug use.

Updated 06/30/2010

Patient's Preferred Infusion Center Location: ☐Downtown Dallas ☐NorthPark