briovaRx®

Fax:

Phone:

Dermatology Enrollment Form

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ L40.0 Psoriasis vulgaris
☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis _____
☐ Other Diagnosis: ICD-10 Code _____

Description _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ 200 mg/mL Prefilled Syringe Starter Kit ☐ 200 mg/mL Vial Kit ☐ 200 mg/mL Prefilled Syringe			
☐ Cosentyx®	☐ 150 mg/mL Prefilled Pen ☐ 150 mg/mL Prefilled Syringe ☐ 150 mg/mL (300 mg dose) Prefilled Pen ☐ 150 mg/mL (300 mg dose) Prefilled Syringe			
☐ Dupixent®	☐ 300 mg/2 mL Prefilled Syringe			
☐ Enbrel®	☐ 50 mg/mL SureClick Autoinjector ☐ 25 mg/0.5 mL Prefilled Syringe ☐ Enbrel Mini® ☐ 50 mg/mL Prefilled Syringe ☐ 25 mg Vial 50 mg/mL Cartridge			
☐ Humira®	☐ 40 mg/0.4 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.8 mL Pen ☐ 80 mg/0.8 mL Pen CD/UC/HS Starter Pack (citrate-free) ☐ 80 mg/0.8 mL & 40 mg/0.4 mL Pen PS/UV Starter Pack (citrate-free) ☐ 40 mg/0.8 mL Pen PS/UV Starter Pack ☐ 40 mg/0.4 mL Pen (citrate-free) ☐ 40 mg/0.8 mL Pen CD/UC/HS Starter Pack ☐ 40 mg/0.8 mL Prefilled Syringe			
☐ Ilumya™	☐ 100 mg/mL Prefilled Syringe			
☐ Inflectra®	☐ 100 mg Vial ☐ Starter Pack (28-day)			
☐ Otezla®	☐ 30 mg Tablet ☐ Starter Pack (28-day) ☐ Starter Pack (2-week)			
☐ Remicade®	☐ 100 mg Vial			
☐ Renflexis®	☐ 100 mg Vial			
☐ Siliq®	☐ 210 mg/1.5 mL Prefilled Syringe			
☐ Simponi®	☐ 50 mg/0.5 mL Prefilled Syringe ☐ 50 mg/0.5 mL SmartJect Autoinjector			
☐ Simponi Aria®	☐ 50 mg/4 mL Vial			
☐ Stelara®	☐ 45 mg/0.5 mL Vial ☐ 90 mg/mL Prefilled Syringe ☐ 45 mg/0.5 mL Prefilled Syringe			
☐ Taltz®	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe			
☐ Tremfya®	☐ 100 mg/mL Prefilled Syringe			
☐ Xeljanz®	☐ 5 mg Tablet			
☐ Xeljanz XR®	☐ 11 mg Extended-Release Tablet			
☐ Other _____				

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____