



844.840.1758 | 844.840.1759 | contact@medboxrx.com | www.medboxrx.com

**DERMATOLOGY  
ENROLLMENT  
FORM MEDICATIONS A-L**

Delivery Need By: \_\_\_\_\_ Delivery to:  Patients Home  Physician's Office  Other

PATIENT INFORMATION		PRESCRIBER INFORMATION
Patient Name:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Prescriber Name:
Address:		Address:
City, State, Zip:		City, State, Zip:
Phone:		Phone:
Date of Birth:		Fax:
Social Security Number:		DEA/NPI#:

**INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK**

CLINICAL INFORMATION	
Diagnosis: <input type="checkbox"/> Atopic Dermatitis L20 <input type="checkbox"/> Psoriasis L40 <input type="checkbox"/> Psoriatic arthritis L40.5 <input type="checkbox"/> Hidradenitis Suppurativa L73.2 <input type="checkbox"/> Other	Has the patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last PPD Test <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: / /	Medications failed:
Height: _____ feet _____ inches Weight: _____ lbs.	Medications on:
Allergies:	Other notes:

**PRESCRIPTION INFORMATION**

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
<b>Actemra®</b>	<input type="checkbox"/> 162mg/0.9ml	<input type="checkbox"/> SC every OTHER week <input type="checkbox"/> SC every week <input type="checkbox"/> Other:	<input type="checkbox"/> 4 weeks supply <input type="checkbox"/> Other:	
<b>Botox®</b>	<input type="checkbox"/> 100U VIAL <input type="checkbox"/> 200U VIAL	<input type="checkbox"/> Inject Units every _____ weeks	<input type="checkbox"/> Vials	
<b>Cimzia®</b>	<input type="checkbox"/> 200mg/ml Prefilled SYR <input type="checkbox"/> Starter Kit	<b>Loading Dose:</b> <input type="checkbox"/> Inject 400mg SC at weeks 0,2 and 4 <b>Maintenance Dose:</b> <input type="checkbox"/> 200mg SC every other week <input type="checkbox"/> 400mg SC every 4 weeks	<input type="checkbox"/> 4 week supply	
<b>Cosentyx™</b> *Enhanced Specialty Pharmacy Program Participant	<input type="checkbox"/> 150mg Pen <input type="checkbox"/> 150mg SYR	<b>Loading Dose:</b> <input type="checkbox"/> 150mg 0,1,2,3,4 weeks <input type="checkbox"/> 300mg 0,1,2,3,4 weeks <b>Maintenance Dose:</b> <input type="checkbox"/> 150mg every 4 weeks <input type="checkbox"/> 300mg every 4 weeks	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
<b>Cosentyx™</b> *Enhanced Specialty Pharmacy Program Participant	<input type="checkbox"/> 150mg Pen <input type="checkbox"/> 150mg Syringe	<b>Loading Dose:</b> <input type="checkbox"/> 150mg 0,1,2,3,4 weeks <input type="checkbox"/> 300mg 0,1,2,3,4 weeks <b>Maintenance Dose:</b> <input type="checkbox"/> 150mg every 4 weeks <input type="checkbox"/> 300mg every 4 weeks	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
<b>Covered Until You're Covered</b>				
<b>Dupixent®</b>	<input type="checkbox"/> 300mg/ml Prefilled SYR	<b>Loading Dose:</b> <input type="checkbox"/> Inject two 300mg SC once <b>Maintenance Dose:</b> <input type="checkbox"/> Inject 300mg every other week	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other:	
<b>Enbrel®</b>	<input type="checkbox"/> 50mg/ml Single Use Prefilled SYR <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 25mg/0.5ml Prefilled SYR <input type="checkbox"/> 25mg Vial	<input type="checkbox"/> Inject 50mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> Inject 25mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Other:	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Humira HS Starter Kit</b>	<input type="checkbox"/> 40mg/0.8ml Pen x6 (Starter Kit)  <input type="checkbox"/> 80mg/0.8ml Pen x3 (Citrate-Free)	<b>Loading Dose:</b> <input type="checkbox"/> Inject 160 mg day 1, 80 mg day 15, maintenance beginning on day 29 <b>OR</b> <input type="checkbox"/> Inject 80 mg Day 1, 80mg Day 2, 80mg on Day 15, maintenance beginning on day 29	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Humira® Psoriasis/Uveitis Starter Kit Citrate-Free</b>	<input type="checkbox"/> 40mg/0.8ml Pen x4 (Starter Kit) <input type="checkbox"/> 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2 (Citrate-Free)	<b>Loading Dose:</b> <input type="checkbox"/> Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Humira®</b>	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled SYR  <input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled SYR (Citrate-Free)	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	

Patient is interested in patient support programs

Ancillary supplies provided for administration

Office Contact Name: \_\_\_\_\_ Preferred Phone Number & Extension: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.



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PATIENT INFORMATION		PRESCRIBER INFORMATION
Patient Name:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Prescriber Name:
Address:		Address:
City, State, Zip:		City, State, Zip:
Phone:		Phone:
Date of Birth:		Fax:
Social Security Number:		DEA/NPI#:

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Last PPD Test      M/D/Y <input type="checkbox"/> Positive <input type="checkbox"/> Negative      Date: / /	Medications failed:
Height:      Weight: feet      inches      lbs.	Medications on:
Allergies:	Other notes:

**PRESCRIPTION INFORMATION**

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
<b>Inflectra®</b>	<input type="checkbox"/> 100 mg VIAL	<input type="checkbox"/> Induction Dose: 5mg/kg (Dose ____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 5mg/kg (Dose ____mg) IV every 8 weeks	<input type="checkbox"/> ____ Vials	
<b>Otezla®</b>	<input type="checkbox"/> 28 day starter pack titration <input type="checkbox"/> 30mg	<input type="checkbox"/> Initial dosage titration per starter <input type="checkbox"/> pack 30mg twice daily taken orally	<input type="checkbox"/> 1 month starter <input type="checkbox"/> pack Bottle of 60 <input type="checkbox"/> Other:	
<b>Remicade®</b>	<input type="checkbox"/> 100 MG VIAL	<input type="checkbox"/> Induction Dose: 5mg/kg (Dose ____mg) IV at 0, 2, and 6 weeks then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 5mg/kg (Dose ____mg) IV every 8 weeks <input type="checkbox"/> IV mg every ____ weeks	<input type="checkbox"/> ____ Vials	
<b>Renflexis™</b>	<input type="checkbox"/> 100 MG VIAL	<input type="checkbox"/> Induction Dose: 5mg/kg (Dose ____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: 5mg/kg (Dose ____mg) IV every 8 weeks	<input type="checkbox"/> ____ Vials	
<b>Simponi®</b>	<input type="checkbox"/> 100mg/1ml SmartJect Autoinjector <input type="checkbox"/> 100mg/1ml Prefilled SYR <input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled SYR	<input type="checkbox"/> Inject 100mg SC ONCE a month <input type="checkbox"/> Inject 50mg SC ONCE a month	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Siliq™</b>	<input type="checkbox"/> 210mg/1.5ml Prefilled SYR	<input type="checkbox"/> Inject 210mg SC at weeks: 0, 1 and 2 and 210mg SC every 2 weeks thereafter	<input type="checkbox"/> Starter Dose (3 SYR) <input type="checkbox"/> Maintenance Dose (2 SYR)	
<b>Stelara®</b>	<input type="checkbox"/> 45mg/0.5ml Prefilled SYR <input type="checkbox"/> 90mg/ml Prefilled SYR	<input type="checkbox"/> Patients weighing <100kg: Inject 45mg SC at 0 and 4 weeks, then every 12 weeks thereafter <input type="checkbox"/> Patients weighing >100kg: Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter	<input type="checkbox"/> 2 SYR loading <input type="checkbox"/> 1 SYR maintenance	
<b>Taltz ®</b>	<input type="checkbox"/> 80mg/ml single-dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml single-dose Prefilled SYR	Psoriasis Loading Dose: <input type="checkbox"/> Inject 160mg SC at week 0 followed by 80mg SC on weeks 2, 4, 6, 8, 10 and 12 <input type="checkbox"/> Maintenance Dose: Inject 80mg SC every 4 weeks	<input type="checkbox"/> 3 syringes/pens <input type="checkbox"/> 2 syringes/pens <input type="checkbox"/> 1 syringe/pen	
<b>Tremfya®</b>	<input type="checkbox"/> 100mg/ml Prefilled SYR	<input type="checkbox"/> Inject ____ mg at weeks 0, 4, then every 8 weeks thereafter	<input type="checkbox"/> Loading Dose/ 4 week supply <input type="checkbox"/> Maintenance/ 8 week supply	
<b>Other:</b>				
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Office Contact Name: \_\_\_\_\_ Preferred Phone Number & Extension: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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