

# Dermatology

## Enrollment Form



Phone +1.832.939.8137  
Fax: +1.832.939.8128

Patient Demographic Information										(Or Attach Face Sheet from Patient Chart)									
Patient Name				DOB				Gender		Male <input type="checkbox"/> Female <input type="checkbox"/>		Weight		_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg					
SSN		Phone		Allergies															
Address				City				State				Zip Code							
Patient Insurance Information										(Or Attach Copies of Patient's Insurance Card)									
Primary Insurance				Name of the Insured						Relationship									
Member ID#				Group #				Insurance Phone #											
Secondary Rx Carrier								Rx ID #				Rx Group #							
Drug Therapy Information																			
Medication		Directions						Quantity		Refills									
Adbry (tralokinumab-ldrm)		<input type="checkbox"/> 150mg 2 cartons (4 prefilled syringes)																	
		<input type="checkbox"/> 150mg 1 carton (2 prefilled syringes)																	
Amjevita (adalimumab-atto)		<input type="checkbox"/> Single-dose prefilled SureClick autoinjector: 40 mg/0.8 mL																	
		<input type="checkbox"/> Single-dose prefilled syringe: 20 mg/0.4 mL																	
		<input type="checkbox"/> Single-dose prefilled syringe: 40 mg/0.8 mL																	
Cibinqo (abrocitinib)		<input type="checkbox"/> 50mg Tablets																	
		<input type="checkbox"/> 100mg Tablets																	
		<input type="checkbox"/> 200mg Tablets																	
Cimzia (certolizumab pegol)		<input type="checkbox"/> Starter Kit 6x200mg Prefilled Syringes																	
		<input type="checkbox"/> 2x200mg Vials																	
		<input type="checkbox"/> 2x200mg Prefilled Syringes																	
Cosentyx (secukinumab)		<input type="checkbox"/> 75mg Prefilled Syringe																	
		<input type="checkbox"/> 150mg Pen																	
		<input type="checkbox"/> 150mg Prefilled Syringe																	
		<input type="checkbox"/> 2X150mg Pack (300mg) Pen																	
		<input type="checkbox"/> 2X150mg Pack (300mg) Prefilled Syringe																	
Dupixent (dupilumab)		<input type="checkbox"/> 200mg Prefilled Syringe with Needle Shield																	
		<input type="checkbox"/> 300mg Prefilled Syringe with Needle Shield																	
		<input type="checkbox"/> 200mg Pen																	
		<input type="checkbox"/> 300mg Pen																	
Humira (adalimumab)		<input type="checkbox"/> 40mg/0.8ml Prefilled Syringes																	
		<input type="checkbox"/> 40mg/0.8ml Pens																	

# Dermatology

## Enrollment Form



**DELIVERIT™**  
Infusion & Specialty

Phone +1.832.939.8137

Fax: +1.832.939.8128

### Drug Therapy Information

Medication	Directions	Quantity	Refills
<b>Enbrel</b> (etanercept)	<input type="checkbox"/> <b>25mg</b> Prefilled Syringe <input type="checkbox"/> <b>25mg</b> Vial <input type="checkbox"/> <b>50mg</b> Prefilled Syringe <input type="checkbox"/> <b>50mg</b> SureClick™ Pen <input type="checkbox"/> <b>50mg</b> Mini™ Cartridge		
<b>Humira citrate free</b> (adalimumab)	<input type="checkbox"/> <b>80mg/0.8ml &amp; 40mg/0.4ml</b> Psoriasis citrate free Starter Kit <input type="checkbox"/> <b>80mg/0.8ml</b> –Hidradenitis suppurativa citrate free Starter Kit <input type="checkbox"/> <b>40mg/0.4ml</b> citrate free Prefilled Syringes <input type="checkbox"/> <b>40mg/0.4ml</b> citrate free Pens <input type="checkbox"/> <b>80mg/0.8ml</b> citrate free Pens		
<b>Ilumya</b> (tildrakizumab-asmn)	<input type="checkbox"/> <b>100mg/ml</b> Prefilled Syringe		
<b>Inflectra</b> (infliximab-dyyb)	<input type="checkbox"/> <b>100mg</b> Vial		
<b>Litfulo</b>	<input type="checkbox"/> <b>50mg</b> Capsules		
<b>Methotrexate</b>	<input type="checkbox"/> <b>2.5mg</b> Tablet (Can only be ordered with other specialty meds.)		
<b>Olumiant</b> (baricitinib)	<input type="checkbox"/> <b>2mg</b> Tablets <input type="checkbox"/> <b>4mg</b> Tablets		
<b>Orencia</b> (abatacept)	<input type="checkbox"/> <b>250mg</b> Vial <input type="checkbox"/> <b>125mg</b> Prefilled Syringe <input type="checkbox"/> <b>125mg</b> Clickjet Pen		
<b>Otezla</b> (apremilast)	<input type="checkbox"/> Titration Pack <input type="checkbox"/> <b>30mg</b> Tablets		
<b>Remicade</b> (infliximab)	<input type="checkbox"/> <b>100mg</b> Vial		
<b>Renflexis</b> (infliximab-abda)	<input type="checkbox"/> <b>100mg</b> Vial		
<b>Rinvoq</b> (upadacitinib)	<input type="checkbox"/> <b>15mg</b> Tablets <input type="checkbox"/> <b>30mg</b> Tablets		
<b>Siliq</b> (brodalumab)	<input type="checkbox"/> <b>210mg</b> Prefilled Syringe		

# Dermatology

Enrollment Form



Phone +1.832.939.8137  
Fax: +1.832.939.8128

## Drug Therapy Information

Medication	Directions	Quantity	Refills
Simponi (golimumab)	<input type="checkbox"/> 50mg SmartJect™ AutoInjector <input type="checkbox"/> 50mg Prefilled Syringe		
Simponi Aria (golimumab)	<input type="checkbox"/> 50mg Vial		
Skyrizi (risankizumab-rzaa)	<input type="checkbox"/> 150mg Pen <input type="checkbox"/> 150mg Prefilled Syringe		
Sotyku (deucravacitinib)	<input type="checkbox"/> 6mg Tablets		
Stelara (ustekinumab)	<input type="checkbox"/> 45mg Prefilled Syringe <input type="checkbox"/> 45mg Single-dose Via <input type="checkbox"/> 90mg Prefilled Syringe		
Taltz (ixekizumab)	<input type="checkbox"/> 80mg Prefilled Syringe <input type="checkbox"/> 80mg AutoInjector		
Tremfya (guselkumab)	<input type="checkbox"/> 100mg/ml One-Press Patient-Controlled Injector <input type="checkbox"/> 100mg/ml Prefilled Syringe		
Xeljanz	<input type="checkbox"/> 5mg Tablets <input type="checkbox"/> 11mg XR Tablets		
Other	<input type="checkbox"/> _____		

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

## Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #			
Address				City		State		Zip Code	
<input type="checkbox"/> I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.						Date			
<input type="checkbox"/> DAW (Dispense as written).						Prescriber's Signature			
<p><small>Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.</small></p>									
						X_____			