

DERMATOLOGY ENROLLMENT FORM

EMAIL: INFO@BRIGENT.COM
FAX: 818-963-7526
PHONE: 818-963-7525

Brigent Specialty Pharmacy
4766 Park Granada Suite 112,
Calabasas, CA 91302
NPI: 1588300545



Ship to: Patient Physician Other

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: Female Male
 Address: _____ City/State/Zip: _____
 SSN: _____ Allergies: _____
 Phone: _____ Alt Phone: _____
 Email: _____ Preferred Contact: Phone Email
 Parent/Caregiver/Legal Guardian Name (Last, First): _____
 Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Dx: _____
 L20.9 Atopic Dermatitis L73.2 Hidradenitis suppurativa
 L40.0 Plaque Psoriasis (mod to severe) L40.50 Arthropathic Psoriasis, Unspecified
 L40.9 Psoriasis L40.59 Other Psoriatic Arthropathy
 L40.52 Psoriatic Arthritis Other Code: _____ Description: _____
 BSA: _____ Weight: _____ lb/kg Height: _____ in/cm **Treatment status:** New to therapy Continuation of
 therapy date of last treatment ____/____/____
 TB Result: _____ Date: _____ Needs by: ____/____/____

Tried and Failed History:

Medication: _____ Duration: _____
 Response: Intolerant Ineffective Contraindicated Side Effects Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg/ml PFS <input type="checkbox"/> 150mg/ml Sensoready Pen <input type="checkbox"/> 150mg/ml (2-Pen Pack) Sensoready Pen <input type="checkbox"/> 150mg/ml (2 Pack) PFS <input type="checkbox"/> 300mg/2ml PFS <input type="checkbox"/> 300mg/2ml UnoReady Pen	<input type="checkbox"/> Initial Dose: Inject <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg SQ weekly at week 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg SQ every 4 weeks	5 week supply 28 days	None _____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/1ml Starter Kit <input type="checkbox"/> 200mg/1ml PFS	<input type="checkbox"/> Initial Dose: Inject 400mg SQ initially: repeat dose on weeks 2 and 4 For Psoriatic Arthritis <input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks For Plaque Psoriasis <input type="checkbox"/> Maintenance: Inject 400mg SQ every other week <input type="checkbox"/> Alternate Maintenance Dosing for Patients < 90kg: Inject 400mg SQ every 4 weeks	6 SYR 2 SYR 4 SYR 2 SYR	None _____ _____ _____
<input type="checkbox"/> Dupixent (18+ years old)	<input type="checkbox"/> 300mg/2ml PFS <input type="checkbox"/> 300mg/2ml Prefilled Pen	<input type="checkbox"/> Initial Dose: Inject 600mg SQ on day 1 (divided in 2 different injection sites) <input type="checkbox"/> Maintenance: Inject 300mg SQ every 4 weeks starting day 15	2 2	None _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg/ml PFS <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 50mg/ml Enbrel Mini-Cartridge	For Psoriasis <input type="checkbox"/> Initial Dose: Inject 50mg SQ twice a week for 3 months <input type="checkbox"/> Maintenance: Inject 50mg SQ weekly	28 days	2
		For Psoriatic Arthritis <input type="checkbox"/> Inject 50mg SQ weekly	28 days	—
<input type="checkbox"/> Humira	For Psoriasis <input type="checkbox"/> Citrate Free Psoriasis Starter Pack (80mg/0.8ml x1pen, 40mg/0.4ml x2pens) <input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	<input type="checkbox"/> Initial Dose: Inject 80mg SQ once on day 1, then 40mg on day 8, then 40mg every other week <input type="checkbox"/> Maintenance: Inject 40mg SQ every other week	Loading Dose 28 days	None —
	For Hidradenitis Suppurativa (HS) <input type="checkbox"/> Citrate Free HS Starter Pack (80mg/0.8ml x3pens) <input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	<input type="checkbox"/> Initial Dose: Inject 160mg SQ (given in 1 day or over 2 consecutive days) then 80mg SQ on day 15 <input type="checkbox"/> Maintenance: Inject 40mg SQ every week starting day 29 <input type="checkbox"/> Alternate Dose: Citrate Free 80mg/0.8ml Pen Inject 80mg SQ every other week	Loading Dose 28 days 28 days	None — —
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack <input type="checkbox"/> 30mg tablet	<input type="checkbox"/> Titration: Take as directed per package instructions <input type="checkbox"/> Maintenance: Take 30mg tablet orally twice a day every morning and evening	1 pack 60 tabs	None —
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg ER tablet <input type="checkbox"/> 30mg ER tablet	For Atopic Dermatitis For patients ≥ 12 years weighing at least 40kg and adults <65 years old: <input type="checkbox"/> Take 15mg ER tablet by mouth once daily <input type="checkbox"/> Take 30mg ER tablet by mouth once daily (if adequate response not achieved) For patients ≥ 65 years old: <input type="checkbox"/> Take 15mg ER tablet by mouth once daily	30 tabs 30 tabs 30 tabs	— — —
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector <input type="checkbox"/> 50mg/0.5ml PFS	<input type="checkbox"/> Inject 50mg SQ once per month	28 days supply	—
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150mg/ml PFS <input type="checkbox"/> 150mg/ml Prefilled pen	<input type="checkbox"/> Initial Dose: Inject 150mg SQ at week 0 and week 4 <input type="checkbox"/> Maintenance: Inject 150mg SQ every 12 weeks	QS QS	1 —
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5ml PFS <input type="checkbox"/> 90mg/ml PFS	For patients weighing ≤ 100kg (220lbs): <input type="checkbox"/> Initial Dose: Inject 45mg SQ on day 0 then week 4 <input type="checkbox"/> Maintenance: Inject 45mg SQ every 12 weeks	1 PFS 1 PFS	1 —
		For patients weighing ≥ 100kg (220lbs): <input type="checkbox"/> Initial Dose: Inject 90mg SQ on day 0 then week 4 <input type="checkbox"/> Maintenance: Inject 90mg SQ every 12 weeks	1 PFS 1 PFS	1 —

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80mg/1ml Autoinjector <input type="checkbox"/> 80mg/1ml PFS	For Psoriasis <input type="checkbox"/> Initial Dose: Inject 90mg SQ on day 1, then 80mg at week 2; Then inject 80mg at week 4, 6, 8, and 10; Then inject 80mg at week 12	3 2 1	None 1 None
		For Psoriatic Arthritis <input type="checkbox"/> Initial Dose: Inject 160mg SQ at week 0	2	None
		For Psoriasis and Psoriatic Arthritis <input type="checkbox"/> Maintenance: Inject 80mg SQ every 4 weeks after initial dose	1	_____
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg/ml Single-Dose PFS <input type="checkbox"/> 100mg/ml Autoinjector	<input type="checkbox"/> Initial Dose: Inject 100mg SQ at week 0 and on week 4 <input type="checkbox"/> Maintenance: Inject 100mg SQ every 8 weeks	1 1	1 _____
		<input type="checkbox"/> Take 1 tablet orally twice a day every morning and evening <input type="checkbox"/> Take 1 tablet orally once a day	60 tabs 30 tabs	_____ _____
<input type="checkbox"/> Xeljanz <input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 11mg tablet	<input type="checkbox"/> Take 1 tablet orally twice a day every morning and evening <input type="checkbox"/> Take 1 tablet orally once a day	60 tabs 30 tabs	_____ _____
Other: _____		_____	_____	_____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
 Address: _____
 City: _____ Zip: _____ Phone: _____ Fax: _____
 Contact Person: _____ Contact Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP) NY & IA prescriptions must be submitted via e-script

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____
Date: _____

Prescriber's Signature: _____
Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Brigent 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 requests as my signature.