DERMATOLOGY ENROLLMENT FORM

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

IVI Pharmacy, Inc. dba
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
☐ L40.0 Plaque Psoriasis (mod to severe)
☐ L40.9 Psoriasis
☐ L40.52 Psoriatic Arthritis
☐ L73.2 Hidradenitis suppurativa
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ L40.59 Other Psoriatic Arthropathy
☐ Other Code: _______ Description: ____________

BSA: _______Weight: _______ lb/kg Height: _____ in/cm
TB Result: ____________ Date: ____________

Treatment status: ☐ New to therapy ☐ Continuation of therapy date of last treatment ____/____/_____
Needs by: ____/_____/______

Tried and Failed History:
Medication: ________________________ Duration: ________________
Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects ☐ Other: ________________

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ Bimzelx	☐ 160mg PFS ☐ 160mg Autoinjector	**Initial Dose:** Inject 320mg (2 X 160mg injections) SQ at week 0,4,8,12, and 16	2	4
		Maintenance Dose: Inject 320mg SQ every 8 weeks	2	____
		For patients weighing ≥ 120kg: Inject 320mg SQ every 4 weeks	2	____
☐ Cosentyx	☐ 150mg/ml PFS ☐ 150mg/ml Sensoready Pen ☐ 150mg/ml (2-Pen Pack) Sensoready Pen ☐ 150mg/ml (2 Pack) PFS ☐ 300mg/2ml PFS ☐ 300mg/2ml UnoReady Pen	☐ **Initial Dose:** Inject ☐ 150mg ☐ 300mg SQ weekly at week 0, 1, 2, 3, and 4	5 week supply	None
		☐ **Maintenance:** Inject ☐ 150mg ☐ 300mg SQ every 4 weeks	28 days	______
☐ Cimzia	☐ 200mg/1ml Starter Kit ☐ 200mg/1ml PFS	☐ **Initial Dose:** Inject 400mg SQ initially: repeat dose on weeks 2 and 4	6 SYR	None
		For Psoriatic Arthritis ☐ **Maintenance:** Inject 400mg SQ every 4 weeks	2 SYR	_____
		For Plaque Psoriasis ☐ **Maintenance:** Inject 400mg SQ every other week	4 SYR	_____
		☐ **Alternate Maintenance Dosing for Patients < 90kg:** Inject 400mg SQ every 4 weeks	2 SYR	_____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ Dupixent (18+ years old)	☐ 300mg/2ml PFS ☐ 300mg/2ml Prefilled Pen	☐ **Initial Dose:** Inject 600mg SQ on day 1 (divided in 2 different injection sites) ☐ **Maintenance:** Inject 300mg SQ every 2 weeks starting day 15	2 2	None ______
☐ Enbrel	☐ 50mg/ml PFS ☐ 50mg/ml SureClick Autoinjector ☐ 50mg/ml Enbrel Mini-Cartridge	**For Psoriasis** ☐ **Initial Dose:** Inject 50mg SQ twice a week for 3 months ☐ **Maintenance:** Inject 50mg SQ weekly	28 days 28 days	2 ____
		For Psoriatic Arthritis ☐ Inject 50mg SQ weekly	28 days	____
☐ Humira	**For Psoriasis** ☐ Citrate Free Psoriasis Starter Pack (80mg/0.8ml x1pen, 40mg/0.4ml x2pens) ☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	☐ **Initial Dose:** Inject 80mg SQ once on day 1, then 40mg on day 8, then 40mg every other week ☐ **Maintenance:** Inject 40mg SQ every other week	Loading Dose 28 days	None ____
	For Hidradenitis Suppurativa (HS) ☐ Citrate Free HS Starter Pack (80mg/0.8ml x3pens) ☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	☐ **Initial Dose:** Inject 160mg SQ (given in 1 day or over 2 consecutive days) then 80mg SQ on day 15 ☐ **Maintenance:** Inject 40mg SQ every week starting day 29 ☐ **Alternate Dose:** Citrate Free 80mg/0.8ml Pen Inject 80mg SQ every other week	Loading Dose 28 days 28 days	None ____ ____
☐ Opzelura	1.5% cream	Apply a thin layer to the affected area(s) twice daily	60gm	____
☐ Otezla	☐ Titration Starter Pack ☐ 30mg tablet	☐ **Titration:** Take as directed per package instructions ☐ **Maintenance:** Take 30mg tablet orally twice a day every morning and evening	1 pack 60 tabs	None ______
☐ Rinvoq	☐ 15mg ER tablet ☐ 30mg ER tablet	**For Atopic Dermatitis** **For patients ≥ 12 years weighing at least 40kg and adults <65 years old:** ☐ Take 15mg ER tablet by mouth once daily ☐ Take 30mg ER tablet by mouth once daily (if adequate response not achieved) **For patients ≥ 65 years old:** ☐ Take 15mg ER tablet by mouth once daily	30 tabs 30 tabs 30 tabs	______ ______ ______
☐ Simponi	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml PFS	☐ Inject 50mg SQ once per month	28 days supply	______
☐ Skyrizi	☐ 150mg/ml PFS ☐ 150mg/ml Prefilled pen	☐ **Initial Dose:** Inject 150mg SQ at week 0 and week 4 ☐ **Maintenance:** Inject 150mg SQ every 12 weeks	QS QS	1 ____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ Stelara	☐ 45mg/0.5ml PFS ☐ 90mg/ml PFS	**For patients weighing ≤ 100kg (220lbs):** ☐ **Initial Dose:** Inject 45mg SQ on day 0 then week 4 ☐ **Maintenance:** Inject 45mg SQ every 12 weeks **For patients weighing ≥ 100kg (220lbs):** ☐ **Initial Dose:** Inject 90mg SQ on day 0 then week 4 ☐ **Maintenance:** Inject 90mg SQ every 12 weeks	1 PFS 1 PFS 1 PFS 1 PFS	1 _____ 1 _____
☐ Taltz	☐ 80mg/1ml Autoinjector ☐ 80mg/1ml PFS	**For Psoriasis** ☐ **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 **For Psoriatic Arthritis** ☐ **Initial Dose:** Inject 160mg SQ at week 0	3 2 1 2	None 1 None None
		For Psoriasis and Psoriatic Arthritis ☐ **Maintenance:** Inject 80mg SQ every 4 weeks after initial dose	1	_____
☐ Tremfya	☐ 100mg/ml Single-Dose PFS ☐ 100mg/ml Autoinjector	☐ **Initial Dose:** Inject 100mg SQ at week 0 and on week 4 ☐ **Maintenance:** Inject 100mg SQ every 8 weeks	1 1	1 _______
☐ Xeljanz ☐ Xeljanz XR	☐ 5mg tablet ☐ 11mg tablet	☐ Take 1 tablet orally twice a day every morning and evening ☐ Take 1 tablet orally once a day	60 tabs 30 tabs	_____ _____
☐ Zoryve	0.3% Cream	**Plaque Psoriasis:** Apply to the affected area(s) once daily	60 gm	____
☐ Zoryve	0.3% Foam	**Seborrheic dermatitis:** Apply to the affected area(s) once daily	60 gm	____
Other: ______________________		______________________	_____	____

PRESCRIBER INFORMATION

Prescriber Name: ______________________ NPI: ____________ DEA: ____________ LIC#: __________

Address: ____

City: ________________ Zip: ________ Phone: ____________ Fax: ______________

Contact Person: ______________________________ Contact Phone: ____________________

PRESCRIBER SIGNATURE (DO NOT STAMP)

"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.