# DERMATOLOGY ENROLLMENT FORM

EMAIL: INFO@BRIGENT.COM
FAX: 818-963-7526
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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
BSA: _____Weight: _____ lb/kg Height: _____ in/cm
TB Result: _____ Date: _____

☐ L73.2 Hidradenitis suppurativa
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ L40.59 Other Psoriatic Arthropathy
☐ Other Code: _____ Description: _____
**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 |
|---|---|---|---|---|
| ☐ Cosentyx | ☐ 150mg/ml PFS<br>☐ 150mg/ml Sensoready Pen<br>☐ 150mg/ml (2-Pen Pack) Sensoready Pen<br>☐ 150mg/ml (2 Pack) PFS<br>☐ 300mg/2ml PFS<br>☐ 300mg/2ml UnoReady Pen | ☐ **Initial Dose:** Inject ☐ 150mg ☐ 300mg SQ weekly at week 0, 1, 2, 3, and 4<br>☐ **Maintenance:** Inject ☐ 150mg ☐ 300mg SQ every 4 weeks | 5 week supply<br>28 days | None<br>_____ |
| ☐ Cimzia | ☐ 200mg/1ml Starter Kit<br>☐ 200mg/1ml PFS | ☐ **Initial Dose:** Inject 400mg SQ initially: repeat dose on weeks 2 and 4<br>**For Psoriatic Arthritis**<br>☐ **Maintenance:** Inject 400mg SQ every 4 weeks<br>**For Plaque Psoriasis**<br>☐ **Maintenance:** Inject 400mg SQ every other week<br>☐ **Alternate Maintenance Dosing for Patients < 90kg:** Inject 400mg SQ every 4 weeks | 6 SYR<br>2 SYR<br>4 SYR<br>2 SYR | None<br>_____<br>_____<br>_____ |
| ☐ Dupixent (18+ years old) | ☐ 300mg/2ml PFS<br>☐ 300mg/2ml Prefilled Pen | ☐ **Initial Dose:** Inject 600mg SQ on day 1 (divided in 2 different injection sites)<br>☐ **Maintenance:** Inject 300mg SQ every 4 weeks starting day 15 | 2<br>2 | None<br>_____ |

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BRIGENT SPECIALTY PHARMACY

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

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|---|---|---|---|---|
| ☐ Taltz | ☐ 80mg/1ml Autoinjector<br>☐ 80mg/1ml PFS | **For Psoriasis**<br>☐ **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<br><br>**For Psoriatic Arthritis**<br>☐ **Initial Dose:** Inject 160mg SQ at week 0 | 3<br>2<br>1<br><br>2 | None<br>1<br>None<br><br>None |
| | | **For Psoriasis and Psoriatic Arthritis**<br>☐ **Maintenance:** Inject 80mg SQ every 4 weeks after initial dose | 1 | _____ |
| ☐ Tremfya | ☐ 100mg/ml Single-Dose PFS<br>☐ 100mg/ml Autoinjector | ☐ **Initial Dose:** Inject 100mg SQ at week 0 and on week 4<br>☐ **Maintenance:** Inject 100mg SQ every 8 weeks | 1<br>1 | 1<br>_____ |
| ☐ Xeljanz<br>☐ Xeljanz XR | ☐ 5mg tablet<br>☐ 11mg tablet | ☐ Take 1 tablet orally twice a day every morning and evening<br>☐ Take 1 tablet orally once a day | 60 tabs<br>30 tabs | _____<br>_____ |
| 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<br><br>**Prescriber's Signature: _____**<br>**Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br><br>**Prescriber's Signature: _____**<br>**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.