ardon

Dermatology Enrollment Form
Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email: _____
Primary Language: _____
Height: _____ Weight: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date: _____ **Ship to:** ☐ Patient ☐ Physician ☐ Other: _____

Date of Diagnosis: **Diagnosis:** ☐ L40.0 Psoriasis Vulgaris ☐ L40.59 Psoriatic Arthritis ☐ L50.1 Idiopathic Urticaria ☐ L20.9 Atopic Dermatitis ☐ L73.2 Hidradenitis Suppurativa ☐ New diagnosis ☐ Other _____

Prior Therapies	Medication	Reason for Discontinuation	Prior Therapies	Medication	Reason for Discontinuation
☐ Biologics			☐ UVB		
☐ Methotrexate			☐ Topical		
☐ Oral Meds			☐ Other		
☐ PUVA					

Current Medications: _____ **Is the patient also taking methotrexate?** ☐ Yes ☐ No

Allergies: _____ **Does the patient have a latex allergy?** ☐ Yes ☐ No

Is the patient new to therapy? ☐ Yes ☐ No

BSA affected by ____%

Has patient had positive TB test? ☐ Yes ☐ No If yes, date of last chest x-ray: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refill
☐ Cibinqo®	☐ 50mg Tablet ☐ 100mg Tablet ☐ 200mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 30 Tablets	____
☐ Cimzia®	**Starter Dose** ☐ Starter Kit (200mg/mL Prefilled Syringes)	☐ Inject 400mg SC at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS	0
	Maintenance Dose ☐ 200mg/mL Prefilled Syringe	☐ Inject 400mg SC every 2 weeks ☐ Inject 400mg SC every 4 weeks ☐ Inject 200mg SC every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS	____
☐ Cosentyx®	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Sensoready Pen ☐ 75mg/0.5mL Prefilled Syringe (pediatric)	☐ Psoriasis Initiation Dose: Inject 300mg SC Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29	☐ 8 Pens/PFS	0
		☐ Psoriasis Maintenance Dose: Inject 300mg SC starting Day 29 & then every 4 weeks thereafter	☐ 2 Pens/PFS	____
		☐ Psoriasis Initiation Dose (pediatric < 50 kg): Inject 75 mg SC Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29	☐ 4 PFS	0
		☐ Psoriasis Maintenance Dose (pediatric < 50 kg): Inject 75mg SC starting Day 29 & then every 4 weeks thereafter	☐ 1 PFS	____

X _____ **X** _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

Ancillary supplies and kits will be provided as needed for administration.

PHYSICIAN SIGNATURE REQUIRED

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Dupixent®	☐ 100mg/0.67mL Prefilled Syringe ☐ 200mg/1.14mL Pen ☐ 200mg/1.14mL Prefilled Syringe ☐ 300mg/2mL Pen ☐ 300mg/2mL Prefilled Syringe	☐ Atopic Dermatitis Initiation Dose (adults and pediatric ≥ 60 kg): Inject 600mg SC on Day 1, followed by 300mg once every 2 weeks starting on day 15.	☐ 4 Pens/PFS	0
		☐ Atopic Dermatitis Maintenance Dose (adults and pediatric >60 kg): Inject 300mg SC every 2 weeks	☐ 2 Pens/PFS	____
		☐ Atopic Dermatitis Initiation Dose (pediatric 6-17 years, 30-59 kg): Inject 400mg SC on Day 1, followed by 200mg every 2 weeks starting on day 15.	☐ 4 Pens/PFS	0
		☐ Atopic Dermatitis Maintenance Dose (pediatric 6-17 years, 30-59 kg): Inject 200mg SC every 2 weeks.	☐ 2 Pens/PFS	____
		☐ Atopic Dermatitis Initiation Dose (pediatric 6-17 years, 15 to 29 kg): Inject 600mg SC on Day 1, followed by 300mg every 4 weeks starting on day 29.	☐ 2 Pens/PFS	0
		☐ Atopic Dermatitis Maintenance Dose (pediatric 6-17 years, 15 to 29 kg): Inject 300mg SC every 4 weeks.	☐ 2 Pens/PFS	____
☐ Enbrel®	☐ 50mg/mL Sureclick™ ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL Mini Cartridge ☐ 25mg/0.5mL Prefilled Syringe ☐ 25mg/0.5mL Single-dose Vial	☐ Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing	____	____
		☐ Psoriasis Maintenance Dose: Inject 50mg SC ONCE a week	____	____
		☐ Other: ____	____	____
☐ Humira®	**Starter Dose** ☐ 40mg/0.8mL Pen Psoriasis Starter (4 pens)	☐ Inject 80mg SC day 1, 40mg Day 8, then 40mg every 14 days thereafter ☐ Other: _____	☐ 1 Kit	0
	Maintenance Dose ☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL Prefilled Syringe ☐ 20mg/0.4mL Prefilled Syringe ☐ 10mg/0.2mL Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC every week ☐ Other: _____	☐ 2 Pens/PFS ☐ 4 Pens/PFS	____
☐ Humira® (Citrate-free)	**Starter Dose** ☐ 80mg/0.8mL and 40 mg/0.4mL Pen Psoriasis Starter (3 pens) ☐ 40mg/0.4mL Pen Psoriasis Starter (4 pens)	☐ Inject 80mg SC day 1, 40mg Day 8, then 40mg every 14 days thereafter ☐ Other: _____	☐ 1 Kit	0
	Maintenance Dose ☐ 40mg/0.4mL CF Pen ☐ 40mg/0.4mL CF Prefilled Syringe ☐ 20mg/0.2mL CF Prefilled Syringe ☐ 10mg/0.1mL CF Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC every week ☐ Other: _____	☐ 2 Pens/PFS ☐ 4 Pens/PFS	____
☐ Ilumya ®	☐ 100mg/mL Prefilled Syringe	☐ Initiation Dose: Inject 100mg SC at weeks 0 and 4, then every 12 weeks thereafter	☐ 1 PFS	0
		☐ Maintenance Dose: Inject 100mg SC every 12 weeks	☐ 1 PFS	____
☐ Otezla®	☐ Starter Pack ☐ 30mg Tablet	☐ Initiation Dose: Take as directed per package instructions	☐ 1 Starter Kit (55 tablets)	0
		☐ Maintenance Dose: Take 1 tablet by mouth twice daily	☐ 60 Tablets	____
☐ Remicade®	☐ 100mg vial	☐ Induction: Infuse ____mg IV at weeks 0, 2, and 6 ☐ Maintenance: Infuse ____mg IV at every 8 weeks	☐ ____# Vial(s)	____
☐ Rinvoq®	☐ 15mg Tablet ☐ 30mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 30 Tablets	____
☐ Skyrizi®	☐ 150mg/mL Pen ☐ 150mg/mL Prefilled Syringe	☐ Initiation Dose: Inject 150mg SC at week 0 and 4, followed by every 12 weeks thereafter	☐ 1 Pen/PFS	0
		☐ Maintenance Dose: Inject 150mg SC every 12 weeks	☐ 1 Pen/PFS	____
☐ Stelara®	☐ 45mg/0.5mL Prefilled Syringe ☐ 45mg/0.5mL Single-dose Vial ☐ 90mg/mL Prefilled Syringe	☐ Initiation Dose: Inject 1 prefilled syringe SC at weeks 0 and 4, and then every 12 weeks thereafter	☐ 1 PFS	0
		☐ Maintenance Dose: Inject 1 prefilled syringe SC every 12 weeks ☐ Other: _____	☐ 1 PFS ____	____

X _____ **X** _____

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Taltz®	☐ 80mg/mL Prefilled Syringe ☐ 80mg/mL Pen	☐ Psoriasis Initiation Dose: Inject 160mg SC week 0, followed by 80mg week 2, 4, 6, 8, 10, 12 and then every 4 weeks thereafter	☐ 8 Pens/PFS	0
		☐ Maintenance Dose: Inject 80mg SC every 4 weeks ☐ Other: _____	☐ 1 Pen/PFS ____	____
☐ Tremfya®	☐ 100mg/mL Prefilled Syringe ☐ 100mg/mL One-Press Injector	☐ Initiation Dose: Inject 100mg SC week 0, week 4, and then every 8 weeks thereafter	☐ 1 Pen/PFS	0
		☐ Maintenance Dose: Inject 100mg SC every 8 weeks	☐ 1 Pen/PFS	____
☐ Xolair®	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Vial	☐ Inject 150mg SC once every 4 weeks	☐ 1 PFS/Vial	____
		☐ Inject 300mg SC once every 4 weeks	☐ 2 PFS/Vial	____

X _____ PRODUCT SUBSTITUTION PERMITTED (Date)

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