DERMATOLOGY **ENROLLMENT FORM**

GREENHILL PLUS+
Specialty Pharmacy Solution
Connection • Care • Community
Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Patient Information

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender ○ M ○ F
Language Preference: ○ English ○ Spanish ○ Other _____

Prescriber Information

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Contact Person _____ Phone _____

Medical Information: Section must be completed to process prescription. (Attach separate sheets as needed)

Diagnosis - Please include diagnosis name with ICD-10 code

○ L40.0 Psoriasis vulgaris
○ L40.1 Generalized pustular psoriasis
○ L40.2 Acrodermatitis continua
○ L40.3 Pustulosis palmaris et plantaris
○ L40.4 Guttate psoriasis
○ L50.54 Psoriatic juvenile arthopathy
○ L40.59 Other psoriatic arthopathy
○ L73.2 Hidradenitis suppurativa
○ L40.8 Other psoriasis _____

Other Diagnosis: ICD-10 Code _____
Description _____
Date of Diagnosis _____
Has a TB test been performed? ○ Yes ○ No
Does the patient have an active infection? ○ Yes ○ No

Start Date _____ **Review Date** _____

Additional Information

Therapy: ○ **New** ○ **Reauthorization** ○ **Restart**

Weight _____ kg/lbs Height _____ cm/in
Allergies _____
Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments _____

Injection Training Required: ○ Yes ○ No

Prescription Information

Drugs	Direction	Quantity	Refills
Cimzia®	○Inject 400 mg SQ weeks 0, 2, and 4	○ 6x200 mg/ml	
○PFS	○Inject 200 mg SQ every 2 weeks	○ 2x200 mg/ml	
○Vials	○Inject 400 mg SQ every 4 weeks		
Consentyx®	○Inject 150 mg SQ once weekly at weeks 0, 1, 2 and 3	○ 4x150mg/ml	
○Sensoready Pen	○Inject 300 mg SQ once weekly at weeks 0, 1, 2 and 3	○ 8x150mg/ml	
○PFS	○Inject 150 mg SQ on week 4 and every 4 weeks thereafter	○ 1x150mg/ml	
	○Inject 300 mg SQ on week 4 and every 4 weeks thereafter	○ 2x150mg/ml	
Dupixent®	○Inject 600 mg SQ on Day 1, 300 mg Day 15 and every 2 weeks thereafter	○ 4x300mg/2ml	
○PFS	○Inject 300 mg SQ every 2 weeks	○ 2x300mg/2ml	
Enbrel®	○Inject 50 mg twice weekly (72 h-96h apart) x 3 months	○ 8x50mg/ml	
○Sure Click Auto	○Inject 50 mg SQ once weekly	○ 4x50mg/ml	
○PFS			
Humira®	○PS: Inject 80 mg SQ on Day 1, 40 mg Day 8, then 40 mg every 2 weeks thereafter	○ 4x40mg/0.8ml	
○Pens	○PS: Inject 40 mg SQ every 2 weeks	○ 2x40mg/0.8ml	
○PFS	○HS: Inject 160 mg SQ on Day 1 , then 80 mg on Day 15	○ 6x40mg/0.8ml	
	○HS: Inject 40 mg SQ on day 29 and every week thereafter	○ 4x40mg/0.8ml	
Other			

Drugs	Direction	Quantity	Refills
Otezla®	○Follow package instructions	○ 55 tablets	
○Starter Pack	○Take 30 mg po bid	○ 60 tablets	
○Maintenance	○Other sig:		
Siliq™	○Inject 210 mg SQ on weeks 0, 1, and 2 followed by 210 mg SQ every 2 weeks thereafter	○ 3x210mg/1.5m	
○PFS	○Inject 210 mg SQ every weeks	○ 2x210mg/1.5ml	
Simponi®	○Inject 50 mg SQ once monthly	○ 1x50mg/0.5ml	
○SmartJect®			
○PFS			
Stelara®	○Inject 45 mg SQ on Day 1 (≤100 kg)	○ 1x45mg/0.5ml	
○Office Inject	○Inject 90 mg SQ on Day 1 (>100 kg)	○ 1x90mg/ml	
○Self Inject	○Inject 45 mg SQ Day 29 and 12 weeks thereafter (≤100 kg)	○ 1x45mg/0.5ml	
		○ 1x90mg/ml	
Taltz®	○Weeks 0-2: Inject 160 mg SQ at week 0, then 80 mg	○ 3x80mg/ml	
○Auto Injector	○Weeks 4-10: Inject 80 mg SQ at week 4 and every two weeks thereafter through week 10	○ 2x80mg/ml	
○PFS	○Week 12 onwards: Inject 80 mg SQ at week 12 and every four weeks thereafter	○ 1x80mg/ml	

Patient Authorization: I authorize this pharmacy to enroll me in the manufacturer's patient support program checked above to receive services such as, but not limited to, injection training. I further authorize this pharmacy to share minimum necessary information about my health condition and treatment to the manufacturer's program to provide disease state education materials, delivery of products and services offered by the program, and aggregated de-identified data for market analysis. I understand that may revoke this authorization at any time by contacting this pharmacy. I also understand that I may refuse to sign this authorization and I will be eligible for treatment by this pharmacy.

Patient's Signature _____ ***Date*** _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED

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NEW REFERRAL CHECKLIST
PLEASE USE THIS CHECKLIST FOR DERMATOLOGY PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days. ***Please forward to us any updates you receive from the insurance company regarding approvals or denials.***

REQUIRED INFORMATION:

- ☐ Patient Name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc.)
- ☐ Clinical notes
- ☐ Labs (TB test, Hep B)
- ☐ Insurance information with prescription insurance. Please include a copy of card.
  If only medical insurance card is provided, please include local pharmacy information.
- ☐ Prescriber Signature
- ☐ Date Written
- ☐ Previous Treatments
- ☐ Disease Severity
- ☐ For new referrals check both starter and maintenance sig

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Fax: 302-513-9396

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