Dermatology Enrollment Form A-E

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

Date: _____

Patient Name: _____

Date of Birth: _____

CLINICAL INFORMATION

Fax Copy of Insurance Card (front and back), Demographics, Clinic Notes, Lab Results, and List of Current Medications

Weight: _____ lbs OR _____ kg Height: _____ in OR _____ cm Drug Allergies: _____

☐ TB Test: _____ No _____ Yes, Date: _____ Results: _____ *(Please Send Lab Results)*

DIAGNOSIS:

- ☐ C44. _____ Basal Cell Carcinoma
- ☐ L40.0 Moderate to Severe Plaque Psoriasis
- ☐ L63.9 Alopecia Areata
- ☐ Other: _____
- ☐ L20. _____ Atopic Dermatitis
- ☐ L40.50 Psoriatic Arthritis
- ☐ L73.2 Hidradenitis Suppurativa- Hurley Stage: _____
- ICD-10 Code: _____
- ☐ L28.1 Prurigo Nodularis
- ☐ L50. _____ Urticaria
- ☐ L80 Vitiligo

Is the patient currently on therapy? _____ Yes _____ No

Last Dose: _____

Next Dose Due: _____

Prior Failed Medications: _____

Length of Treatment: _____

Reason for Discontinuing: _____

_____

DELIVER TO:

- ☐ Physician's Office
- ☐ TwelveStone Infusion Center
- ☐ Other: _____
- ☐ Patient's Home
- ☐ 1st Dose to MD's Office, Remaining Refills to Patient Home

TRAINING:

- ☐ Patient Has Received Injection Training
- ☐ Physician's Office to Provide Injection Training
- ☐ Pharmacy to Coordinate Injection Training

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ BOTOX	100 unit Vial	☐ Inject 50 units per axilla as directed		
☐ CIMZIA	**Initial Dose** ☐ Cimzia Starter Kit (six 200mg PFS)	☐ Inject 400mg (two injections) SQ at weeks 0, 2, and 4, then maintenance dose		
	Maintenance Dose ☐ 200mg PFS ☐ 200mg Vial	☐ Inject 200mg SQ every 2 weeks ☐ Inject 400mg (two 200mg injections) SQ every 2 weeks ☐ Inject 400mg (two 200mg injections) SQ every 4 weeks		
☐ CIBINQO	☐ 50mg ☐ 100mg ☐ 200mg	☐ Take one tablet by mouth once daily		
☐ COSENTYX	☐ 150mg/ml Pen	☐ Inject 300mg SQ at weeks 0, 1, 2, 3, 4 followed by 300mg every 4 weeks thereafter		
	☐ 150mg/ml PFS ☐ 150mg Vial	☐ Maintenance- Inject 150mg SQ every 4 weeks ☐ Maintenance- Inject 300mg SQ every 4 weeks		
☐ DUPIXENT	☐ 300mg/2ml PFS	☐ Initiation- Initial dose of 600mg (two 300mg injections), followed by 300mg every other week		
	☐ 300mg/2ml Pen	☐ Maintenance- Inject 300mg SQ every other week		
☐ ENBREL	☐ 50mg/ml Sureclick Pen	☐ Initiation- Inject 50mg SQ twice weekly x 3 months; then 50mg weekly thereafter		
	☐ 50mg/ml PFS ☐ 50mg/ml Enbrel Mini	☐ Maintenance- Inject 50mg SQ once weekly		
☐ ERIVEDGE	150mg Capsules	☐ Take 1 (one) capsule by mouth daily		

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

Dermatology Enrollment Form H-I

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

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Toll Free: (844) 893-0012

CLINICAL INFORMATION

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DIAGNOSIS:

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- ☐ Other: _____
- ☐ L20. _____ Atopic Dermatitis
- ☐ L40.50 Psoriatic Arthritis
- ☐ L73.2 Hidradenitis Suppurativa- Hurley Stage: _____
- ICD-10 Code: _____
- ☐ L28.1 Prurigo Nodularis
- ☐ L50. _____ Urticaria
- ☐ L80 Vitiligo

Is the patient currently on therapy? _____ Yes _____ No

Last Dose: _____

Next Dose Due: _____

Prior Failed Medications: _____

Length of Treatment: _____

Reason for Discontinuing: _____

_____

DELIVER TO:

- ☐ Physician's Office
- ☐ TwelveStone Infusion Center
- ☐ Other: _____
- ☐ Patient's Home
- ☐ 1st Dose to MD's Office, Remaining Refills to Patient Home

TRAINING:

- ☐ Patient Has Received Injection Training
- ☐ Physician's Office to Provide Injection Training
- ☐ Pharmacy to Coordinate Injection Training

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ HUMIRA	40mg/0.8ml ☐ Pen ☐ PFS 40mg/0.4ml (CF) ☐ Pen ☐ PFS 80mg/0.8ml (CF) ☐ Pen ☐ 40mg/0.8ml Pen Starter Pack for Crohn's, UC, or HS ☐ 40mg/0.4ml (CF) Pen Starter Pack for Crohn's, UC, or HS ☐ 80mg/0.8ml (CF) Pen Starter Pack for Crohn's, UC, or HS	☐ Initiation (Psoriasis)- Inject 80mg SQ on Day 1, then 40mg on Day 8 and Day 22 ☐ Maintenance- Inject 40mg SQ every other week ☐ Initiation (HS)- Inject 160mg SQ on Day 1, then 80mg on Day 15, and begin maintenance dose on Day 29 ☐ Maintenance- ☐ Inject 40mg SQ every week ☐ Inject 80mg SQ every other week		
☐ ILUMYA	100mg/ml PFS	☐ Initiation- Inject 100mg SQ at week 0, week 4 and every 12 weeks thereafter ☐ Maintenance- Inject 100mg SQ every 12 weeks		

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Dermatology Enrollment Form O-R

TwelveStone Health Partners

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Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

Date: _____

Patient Name: _____

Date of Birth: _____

CLINICAL INFORMATION

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- ☐ L63.9 Alopecia Areata
- ☐ Other: _____
- ☐ L20. _____ Atopic Dermatitis
- ☐ L40.50 Psoriatic Arthritis
- ☐ L73.2 Hidradenitis Suppurativa- Hurley Stage: _____
- ICD-10 Code: _____
- ☐ L28.1 Prurigo Nodularis
- ☐ L50. _____ Urticaria
- ☐ L80 Vitiligo

Is the patient currently on therapy? _____ Yes _____ No

Last Dose: _____

Next Dose Due: _____

Prior Failed Medications: _____

Length of Treatment: _____

Reason for Discontinuing: _____

_____

DELIVER TO:

- ☐ Physician's Office
- ☐ TwelveStone Infusion Center
- ☐ Other: _____
- ☐ Patient's Home
- ☐ 1st Dose to MD's Office, Remaining Refills to Patient Home

TRAINING:

- ☐ Patient Has Received Injection Training
- ☐ Physician's Office to Provide Injection Training
- ☐ Pharmacy to Coordinate Injection Training

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ ODOMZO	200mg Capsule	☐ Take 1 (one) capsule by mouth daily at least one hour before or two hours after a meal		
☐ OLUMIANT	☐ 2mg ☐ 4mg	☐ Take one tablet by mouth once daily		
☐ OPZELURA	☐ 1.5% Cream	☐ Apply a thin layer twice daily to affected areas of up to 20% body surface area ☐ Apply a thin layer twice daily to affected areas of up to 10% body surface area	☐ 60gm ☐ 100gm	
☐ OTEZLA	☐ Starter Pack ☐ 30mg Tablets	☐ Initiation- Titrate dose up to 30mg PO BID starting with 10mg q AM ☐ Maintenance- Take 1 (one) tablet by mouth twice daily		
☐ OTREXUP	☐ _____mg Autoinjector	☐ Inject ____mg SQ weekly (10-25mg usual dose)		
☐ RASUVO	☐ _____mg Autoinjector	☐ Inject ____mg SQ weekly (10-25mg usual dose)		
☐ RINVOQ	☐ 15mg ☐ 30mg	☐ Take one tablet by mouth once daily		

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Dermatology Enrollment Form S-Z

TwelveStone Health Partners

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Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

Date: _____

Patient Name: _____

Date of Birth: _____

CLINICAL INFORMATION

Fax Copy of Insurance Card (front and back), Demographics, Clinic Notes, Lab Results, and List of Current Medications

Weight: _____ lbs OR _____ kg Height: _____ in OR _____ cm Drug Allergies: _____

☐ TB Test: _____ No _____ Yes, Date: _____ Results: _____ *(Please Send Lab Results)*

DIAGNOSIS:

☐ C44. _____ Basal Cell Carcinoma
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ L63.9 Alopecia Areata
☐ Other: _____

☐ L20. _____ Atopic Dermatitis
☐ L40.50 Psoriatic Arthritis
☐ L73.2 Hidradenitis Suppurativa- Hurley Stage: _____
ICD-10 Code: _____

☐ L28.1 Prurigo Nodularis
☐ L50. _____ Urticaria
☐ L80 Vitiligo

Is the patient currently on therapy? _____ Yes _____ No

Last Dose: _____
Next Dose Due: _____
Prior Failed Medications: _____
Length of Treatment: _____
Reason for Discontinuing: _____

DELIVER TO:

☐ Physician's Office
☐ TwelveStone Infusion Center
☐ Other: _____
☐ Patient's Home
☐ 1st Dose to MD's Office, Remaining Refills to Patient Home

TRAINING: ☐ Patient Has Received Injection Training
☐ Physician's Office to Provide Injection Training
☐ Pharmacy to Coordinate Injection Training

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ SILIQ	210mg PFS	☐ Initiation- Inject 210mg SQ at weeks 0, 1, and 2 followed by 210mg every 2 weeks thereafter ☐ Maintenance- Inject 210mg SQ every 2 weeks		
☐ SKYRIZI	☐ 150mg PFS ☐ 150mg Pen	☐ Initiation- Inject 150mg SQ at week 0, week 4 and every 12 weeks thereafter ☐ Maintenance- Inject 150mg SQ every 12 weeks		
☐ SOTYKTU	☐ 6mg	☐ Take one tablet by mouth once daily		
☐ STELARA	☐ 45mg PFS ☐ 45mg Vial	☐ Initiation (less than or equal to 100kg)- Inject 45mg SQ at weeks 0 and 4, then 45mg every 12 weeks thereafter ☐ Maintenance (less than or equal to 100kg)- Inject 45mg SQ every 12 weeks		
	☐ 90mg PFS	☐ Initiation (greater than 100kg)- Inject 90mg SQ at weeks 0 and 4, then 90mg every 12 weeks thereafter ☐ Maintenance (greater than 100kg)- Inject 90mg SQ every 12 weeks		
☐ TALTZ	☐ 80mg/ml Autoinjector ☐ 80mg/ml PFS	☐ Initiation- Inject 160mg (two 80mg injections) SQ at week 0 followed by 80mg at weeks 2, 4, 6, 8, 10 , and 12, then 80mg every 4 weeks ☐ Maintenance- Inject 80mg SQ every 4 weeks		
☐ TREMFYA	☐ 100mg/ml PFS ☐ 100mg/ml One-Press Autoinjector	☐ Initiation- Inject 100mg SQ at week 0, week 4 and every 8 weeks thereafter ☐ Maintenance- Inject 100mg SQ every 8 weeks		
☐ XOLAIR	☐ 150mg Vial ☐ 150mg PFS	☐ Inject 150mg SQ every 4 weeks ☐ Inject 300mg SQ every 4 weeks		

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