Dermatology Enrollment Form A-D

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

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
- ☐ L45.50 Psoriatic Arthritis
- ☐ L73.2 Hidradenitis Suppurativa- Hurley Stage: _____
- ☐ L28.1 Prurigo Nodularis
- ☐ L50. _____ Urticaria
- ☐ L80 Vitiligo

ICD-10 Code: _____

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
☐ BIMZELX	☐ 160mg/ml PFS ☐ 160mg/ml Autoinjector	☐ Initiation- Inject 320mg (two160mg injections) SQ at weeks 0, 4, 8, 12 and 16 Maintenance- ☐ Inject 320mg (two160mg injections) every 8 weeks ☐ Inject 320mg (two160mg injections) every 4 weeks (may consider for ≥ 120kg)		
☐ BOTOX	100 unit Vial	☐ Inject 50 units per axilla as directed		
☐ CIMZIA	**Initial Dose** ☐ Cimzia Starter Kit (six 200mg PFS) **Maintenance Dose** ☐ 200mg PFS ☐ 200mg Vial	☐ Inject 400mg (two injections) SQ at weeks 0, 2, and 4, then maintenance dose ☐ 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 ☐ 150mg/ml PFS ☐ 150mg Vial	☐ Inject 300mg SQ at weeks 0, 1, 2, 3, 4 followed by 300mg every 4 weeks thereafter ☐ Maintenance- Inject 150mg SQ every 4 weeks ☐ Maintenance- Inject 300mg SQ every 4 weeks		
☐ DUPIXENT	☐ 300mg/2ml PFS ☐ 300mg/2ml Pen	☐ Initiation- Initial dose of 600mg (two 300mg injections), followed by 300mg every other week ☐ Maintenance- Inject 300mg SQ every other week		

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

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

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

Dermatology Enrollment Form E-I

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

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

☐ L20. _____ Atopic Dermatitis
☐ L45.50 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
☐ ENBREL	☐ 50mg/ml Sureclick Pen ☐ 50mg/ml PFS ☐ 50mg/ml Enbrel Mini	☐ Initiation- Inject 50mg SQ twice weekly x 3 months; then 50mg weekly thereafter ☐ Maintenance- Inject 50mg SQ once weekly		
☐ ERIVEDGE	150mg Capsules	☐ Take 1 (one) capsule by mouth daily		
☐ 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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Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

V 08.27.24

Dermatology Enrollment Form O-R

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

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- ☐ L20. _____ Atopic Dermatitis
- ☐ L45.50 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: _____

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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

Date: _____

Patient Name: _____

Date of Birth: _____

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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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