

PSORIASIS SPECIALTY CARE PROGRAM

Phone: **888-450-4570** • Fax: **855-838-5857**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ Patient also taking Methotrexate? Yes No
ICD-10: _____ Other: _____ Serious or active infection present? Yes No
TB Test: Positive Negative Date: _____ Hep B ruled out or treatment started? Yes No
LFT: ALT: _____ AST: _____ Date: _____ Does patient have latex allergy? Yes No
Assessment: Moderate Mod to Severe Severe
_____% BSA affected
 Scalp Face Chest Arms Hands Nails
 Back Groin Buttocks Legs Other: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments: **Indicate Drug Name and Length of Treatment:**

Topicals _____
 Methotrexate _____
 Oral Meds _____
 Biologics _____
 UVA UVB _____
 Others _____

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY Refills	
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Lyophilized Powder Vial	<input type="checkbox"/> Inject 400mg SC every other week <input type="checkbox"/> Induction Dose: (Weight <90kg) Inject 400mg SC every other week initially and at weeks 2 and 4 <input type="checkbox"/> Maintenance Dose: (Weight <90kg) Inject 200mg SC every other week		
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector <input type="checkbox"/> 50mg/ml Enbrel Mini™ Prefilled Cartridge <input type="checkbox"/> For Enbrel Mini™ only: AutoTouch™ Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg Lyophilized Powder Multiple Dose Vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Induction Dose: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing <input type="checkbox"/> Maintenance: Inject 50mg SC once a week Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder <input type="checkbox"/> > 138lbs or more: Inject 50mg weekly <input type="checkbox"/> < 138lbs: Inject 0.8mg/kg weekly <input type="checkbox"/> Other: _____	8 4 1 4	2
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Psoriasis Starter Package <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> Hidradenitis Suppurativa Starter Package <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> Patient has signed HUMIRA Complete form	<input type="checkbox"/> Induction Dose: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week <input type="checkbox"/> Maintenance: Inject 40mg SC every other week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Induction Dose: Inject 160mg SC on day 1 (or 80mg on day 1 and 80mg on day 2), then 80mg SC on day 15, then switch to maintenance dose on day 29 <input type="checkbox"/> Maintenance: Inject 40mg SC every week	4 2 6 4	0 0 0
<input type="checkbox"/> ORENCIA®	<input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector <input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 125mg SC once a week	4	
<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> Starter Pack (Titration) <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Starter Pack: Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack <input type="checkbox"/> Maintenance: Take one 30mg tablet by mouth twice daily	1 60	0
<input type="checkbox"/> RASUVO®	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> SIMPONI® (for PsA)	<input type="checkbox"/> 50mg/0.5ml Smartject Injector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45mg/ml Single-Dose Vial <input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs) <input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs) <input type="checkbox"/> Yes or <input type="checkbox"/> No: STELARA SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection	<input type="checkbox"/> Induction Dose: To achieve pediatric dose: <input type="checkbox"/> < 60kg: Inject 0.75mg/kg <input type="checkbox"/> 60kg - 100kg: Inject 45mg SC <input type="checkbox"/> > 100kg: Inject 90mg SC <input type="checkbox"/> Inject the contents of 1 prefilled syringe SC on day 1 <input type="checkbox"/> Maintenance: Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter	1 1 1	0 0 0
<input type="checkbox"/> TREMFYA™	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 100mg/ml SC at weeks 0 and 4 <input type="checkbox"/> Maintenance: Inject 100mg/ml SC every 8 weeks thereafter	2 1	0
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablet	<input type="checkbox"/> Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
<input type="checkbox"/> XELJANZ® XR	<input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	
<input type="checkbox"/> _____				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.
Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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