

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:

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

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

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to 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"/> Inject 400mg SC every other week		
	<input type="checkbox"/> 200mg Lyophilized Powder Vial	<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"/> COSENTYX [®]	<input type="checkbox"/> 150mg/ml Sensoready [®] Pen	<input type="checkbox"/> Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
	<input type="checkbox"/> 150mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
	<input type="checkbox"/> 150mg/ml Lyophilized Powder Vial	<input type="checkbox"/> Maintenance Dose: Inject 150mg SC every four weeks	1	
		<input type="checkbox"/> Maintenance Dose: Inject 300mg SC every four weeks	2	
<input type="checkbox"/> ENBREL [®]	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector	<input type="checkbox"/> Induction Dose: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
	<input type="checkbox"/> 50mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 50mg SC once a week	4	
	<input type="checkbox"/> 25mg Lyophilized Powder Multiple Dose Vial	Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder		
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> > 138lbs or more: Inject 50mg weekly <input type="checkbox"/> < 138lbs: Inject 0.8mg/kg weekly <input type="checkbox"/> Other: _____	4	
<input type="checkbox"/> HUMIRA [®]	<input type="checkbox"/> Psoriasis Starter Package	<input type="checkbox"/> Induction Dose: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	3	0
	<input type="checkbox"/> 80mg/0.8ml Pen	<input type="checkbox"/> Maintenance: Inject 40mg SC every other week		
	<input type="checkbox"/> 40mg/0.4ml Pen	<input type="checkbox"/> Other: _____	2	
	<input type="checkbox"/> 40mg/0.4ml Prefilled Syringe			
	<input type="checkbox"/> 40mg/0.8ml Pen	<input type="checkbox"/> Induction Dose:		
	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="checkbox"/> Inject one 80mg pen SC on day 1, one 80mg pen on day 2, then one 80mg pen on day 15	3	0
<input type="checkbox"/> ORENCIA [®]	<input type="checkbox"/> Hidradenitis Suppurativa Starter Package	<input type="checkbox"/> Maintenance: Inject 40mg SC on day 29 and every week thereafter	4	
	<input type="checkbox"/> 80mg/0.8ml Pen	<input type="checkbox"/> Patient has signed HUMIRA Complete form		
	<input type="checkbox"/> 40mg/0.4ml Pen			
	<input type="checkbox"/> 40mg/0.4ml Prefilled Syringe			
<input type="checkbox"/> OTEZLA [®]	<input type="checkbox"/> 125mg/ml ClickJect [™] Autoinjector	<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	1	0
	<input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Take one 30mg tablet by mouth twice daily	60	
<input type="checkbox"/>	<input type="checkbox"/> 30mg Tablets			

Rasuvo[®], Simponi[®], Stelara[®], Taltz[®], Tremfya[™], Xeljanz[®] and Xeljanz[®] XR are listed alphabetically on respective enrollment forms.

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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