SPECIALTY PHARMACY™
Psoriasis Enrollment Form

Pharmacy Phone: _____

Fax completed forms and prescriptions to _____ or electronically prescribe to Target Pharmacy #XXXX

Date Needed: _____ Preferred Pharmacy Pickup Location: _____

Patient Information

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Email address: _____

Insurance Provider (Please include a copy of front and back of card): _____

ID #: _____ Policy/Group #: _____ Phone #: _____

Name of Insured: _____ Relationship to Insured: _____ Employer: _____

Prescription Card: ☐ Yes ☐ No Carrier: _____ Policy/Group #: _____

Clinical Assessment

Diagnosis/ICD-9: ☐ 696.1 Psoriasis ☐ 696.0 Psoriatic Arthritis ☐ Other: _____

TB/PPD test given? ☐ Y ☐ N
Date of Negative Test: _____
Hepatitis B ruled out? ☐ Y ☐ N
If no, treatment started? ☐ Y ☐ N
Latex allergy? ☐ Y ☐ N

_____ %BSA affected

Do the affected areas include the palms, soles, head, neck, or genitalia? ☐ Y ☐ N

Additional Justification for Drug: _____

Prior Failed Therapies:
☐ Enbrel® ☐ Humira® ☐ Simponi® ☐ Stelera®
☐ Methotrexate ☐ PUVA ☐ Topical: _____
☐ Other: _____

Prescription Information

Medication	Dose	Directions/Frequency	Quantity	Refills
☐ Cimzia® ONLY FOR PSA	**Starter Dose:** ☐ Starter Kit (200 mg prefilled syringes)	☐ 400 mg Sub-Q at weeks 0, 2 and 4	☐ 1 Kit = 6 x 200 mg/mL	0
	Maintenance Dose: ☐ 200 mg/mL PFS	☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS	
☐ Enbrel®	☐ 50 mg/mL Sureclick® Autoinjector ☐ 50 mg/mL PFS ☐ 25 mg/mL PFS	☐ **Psoriasis Induction Dose:** Inject 50 mg Sub-Q twice a week (72-96 hours apart) x 3 months	☐ 8	2
		☐ Inject 50 mg Sub-Q ONCE a week ☐ Other _____	☐ 4	
☐ Humira®	☐ 40 mg/0.8 mL Pens ☐ 40 mg/0.8 mL PFS	☐ **Starter Pack:** 80 mg Sub-Q day 1, 40 mg one week later (Day 8), then 40 mg every other week thereafter	☐ 4	0
		☐ **Maintenance Dose:** 40 mg Sub-Q every two weeks	☐ 2	
☐ Otezla®	☐ **Starter Dose:** (Two week starter pack)	☐ Day 1: 10 mg AM; Day 2: 10 mg AM, 10 mg PM; Day 3: 10 mg AM, 20 mg PM; Day 4: 20 mg AM, 20 mg PM; Day 5: 20 mg AM, 30 mg PM; Day 6 and thereafter: 30 mg twice daily (as indicated on starter pack packaging)	☐ 1 two week starter pack	0
	☐ **Maintenance Dose:** 30 mg tablet	☐ 30 mg twice daily ☐ Other: _____	☐ 28-count carton of 30 mg tablets (2 blister cards containing 14 tablets each) ☐ 60 Tablets	
☐ Simponi® ONLY FOR PSA	☐ 50 mg/0.5 mL SmartJect™ Autoinjector ☐ 50 mg/0.5 mL PFS	☐ Inject 50 mg Sub-Q once a month	☐ 1	
☐ Stelara® Patient eligible for self-injection? ☐ Y ☐ N	☐ 45 mg/0.5 mL PFS ☐ 90 mg/1 mL PFS	☐ **Initiation Dose:** Inject the contents of 1 prefilled syringe Sub-Q initially Day 1	☐ 1	0
		☐ **Maintenance Dose:** Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	☐ 1	

Prescriber Information

Prescriber's Name: _____ Practice/Facility Name: _____

Prescriber NPI/DEA #: _____ Contact: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Best Time to Call: _____

Prescriber's Signature: _____ Date: _____

Pharmacy can accept only original hardcopy prescription drug orders from patients. Faxed prescriptions must be sent directly from prescribing practitioners.

SXX