Psoriasis Enrollment Form (A-E)

PRx

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

DERMA-ERX-19-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ L40.0 Psoriasis Vulgaris
☐ L40.59 Other Psoriatic Arthropathy
☐ L40.8 Other Psoriasis
☐ L40.9 Psoriasis, unspecified
☐ L20.9 Atopic Dermatitis, unspecified
☐ Other: _____

TB Test Completed: ☐ Yes ☐ No
Date of negative test: ____ /____ / ____
If history of latent TB, has patient received treatment?
☐ Yes ☐ No
Please list previously tried/failed therapies & dates:

Immunization History
☐ Influenza:
Date: ____ /____ / ____
Hep B Screening:
☐ Positive ☐ Negative
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refill
☐ **Cimzia®** (certolizumab pegol)	**Initial Dose** ☐ Cimzia starter kit (six 200 mg prefilled syringes)	☐ Inject 400 mg subcutaneously (two 200 mg injections) at weeks 0, 2, and 4, then maintenance dose	1 kit	0
	Maintenance Dose ☐ 200 mg prefilled syringe ☐ 200 mg vial	☐ Inject 200 mg subcutaneously every 2 weeks ☐ Inject 400 mg subcutaneously (two 200 mg injections) every 4 weeks ☐ Inject 400 mg subcutaneously (two 200 mg injections) every 2 weeks		
☐ **Cosentyx®** (secukinumab)	☐ 150 mg Sensoready® pen ☐ 150 mg prefilled syringe	☐ **Initial**: Inject 150 mg subcutaneously at weeks 0, 1, 2, 3, and 4, then maintenance dose ☐ **Maintenance**: Inject 150 mg subcutaneously every 4 weeks		
		☐ **Initial**: Inject 300 mg (two 150 mg injections) subcutaneously at weeks 0, 1, 2, 3, and 4, then maintenance dose ☐ **Maintenance**: Inject 300 mg (two 150 mg injections) subcutaneously every 4 weeks		
☐ **Dupixent®** (dupilumab)	☐ 300 mg prefilled syringe	*Adults or Adolescents (12-17 and ≥ 60 kg)* ☐ **Initial**: Inject 600 mg (two 300 mg injections) subcutaneously on day 1, then maintenance dose starting on day 15 ☐ **Maintenance**: Inject 300 mg subcutaneously every 2 weeks		
	☐ 200 mg prefilled syringe	*Adolescents (12-17 and < 60 kg)* ☐ **Initial**: Inject 400 mg (two 200 mg injections) subcutaneously on day 1, then maintenance dose starting on day 15 ☐ **Maintenance**: Inject 200 mg subcutaneously every 2 weeks		
☐ **Enbrel®** (etanercept)	☐ 25 mg prefilled syringe ☐ 25 mg vial ☐ 50 mg prefilled syringe ☐ 50 mg Sureclick® autoinjector ☐ Mini 50 mg/mL cartridge (use with AutoTouch® autoinjector)	*Psoriatic Arthritis* ☐ Inject 50 mg subcutaneously every week ☐ Inject 25 mg subcutaneously twice a week (72-96 hours apart)		
		Psoriasis ☐ **Initial:** Inject 50 mg subcutaneously twice weekly (72-96 hours apart) for 3 months, then maintenance dose ☐ **Maintenance:** Inject 50 mg subcutaneously once weekly		
☐ **Enstilar®** (calcipotriene and betamethasone)	☐ 60 gm topical foam ☐ 120 gm topical foam	☐ Apply to affected area(s) once daily for up to 4 weeks		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____