Psoriasis Enrollment Form (F-Q)

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 #: _____

DERMF-QRX-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
☐ **Humira®** (adalimumab)	☐ Humira Psoriasis Starter Kit (four 40 mg/0.8 mL prefilled syringes) ☐ Humira Psoriasis Starter Kit (one 80 mg/0.8 mL prefilled syringe and two 40 mg/0.4 mL prefilled syringes) **Citrate-free**	*Psoriasis* ☐ **Initial:** Inject 80 mg subcutaneously on day 1, 40 mg on day 8, then maintenance dose ☐ **Maintenance:** Inject 40 mg subcutaneously every other week	1 kit	0
	☐ 40 mg/0.8 mL pen ☐ 40 mg/0.4 mL pen **Citrate-free** ☐ 40 mg/0.8 mL prefilled syringe ☐ 40 mg/0.4 mL prefilled syringe **Citrate-free**	*Psoriatic Arthritis* ☐ Inject 40 mg subcutaneously every other week ☐ Inject 40 mg subcutaneously every week		
☐ **Ilumya™** (tildrakizumab-asmn)	☐ 100 mg prefilled syringe	☐ **Initial:** Inject 100 mg subcutaneously at weeks 0 and 4, then maintenance dose ☐ **Maintenance:** Inject 100 mg subcutaneously every 12 weeks		
☐ **Inflectra®** (infliximab-dyyb)	☐ 100 mg vial Patient Dosing Weight: _____ kg	☐ **Initial:** Infuse _____ mg/kg at weeks 0, 2, and 6 then maintenance dose (Dose=_____) ☐ **Maintenance:** Infuse _____ mg/kg every 8 weeks (Dose=_____) ☐ Other: _____		
☐ **Orencia®** (abatacept) *Psoriatic Arthritis*	☐ 125 mg prefilled syringe ☐ 125 mg ClickJect™ autoinjector	☐ Inject 125 mg subcutaneously every week		
	☐ 250 mg vial	☐ **Initial:** Infuse _____ mg at weeks 0, 2, and 4 then maintenance dose ☐ **Maintenance:** Infuse _____ mg every 4 weeks ☐ Other: _____		
☐ **Otezla®** (apremilast)	**Initial Dose** ☐ 28-day starter pack (titration)	☐ **Day 1:** 10 mg by mouth every morning **Day 2:** 10 mg by mouth twice daily **Day 3:** 10 mg by mouth every morning and 20 mg every evening **Day 4:** 20 mg by mouth twice daily **Day 5:** 20 mg by mouth every morning and 30 mg every evening **Day 6 and thereafter:** 30 mg by mouth twice daily		
	Maintenance Dose ☐ 30 mg tablets	☐ Take 30 mg by mouth once daily (renal impairment) ☐ Take 30 mg by mouth twice daily		

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: ____ /____ / ____