Psoriasis Enrollment Form (R-S)

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 #: _____

DERMR-SRX-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
□ **Remicade®** (infliximab)	☐ 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: _____		
□ **Renflexis™** (infliximab-abda)	☐ 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: _____		
□ **Simponi®** (golimumab) *Psoriatic Arthritis*	☐ 50 mg SmartJect® autoinjector ☐ 50 mg prefilled syringe	☐ Inject 50 mg subcutaneously once a month		
□ **Simponi ARIA®** (golimumab) *Psoriatic Arthritis*	☐ 50 mg vial	☐ **Initial**: Infuse 2 mg/kg at weeks 0 and 4, then maintenance dose (Dose=_____mg) ☐ **Maintenance**: Infuse 2 mg/kg every 8 weeks (Dose=_____mg)		
□ **Skyrizi™** (risankizumab-rzaa)	☐ 75 mg prefilled syringe	☐ **Initial**: Inject 150 mg (two 75 mg injections) subcutaneously at weeks 0 and 4, then maintenance dose ☐ **Maintenance**: Inject 150 mg (two 75 mg injections) every 12 weeks		
□ **Stelara®** (ustekinumab)	☐ 45 mg prefilled syringe ****Weight ≤ 100 kg****	☐ **Initial**: Inject 45 mg subcutaneously at 0 and 4 weeks, then maintenance dose ☐ **Maintenance**: Inject 45 mg subcutaneously every 12 weeks		
	☐ 90 mg prefilled syringe ****Weight > 100 kg****	☐ **Initial**: Inject 90 mg subcutaneously at 0 and 4 weeks, then maintenance dose ☐ **Maintenance**: Inject 90 mg subcutaneously every 12 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: ____ /____ / ____