



Psoriasis

Delivery Need By: _____ Deliver to: Patient's Home Physician's Office Other

PATIENT INFORMATION

Patient Name: _____ Male
Address: _____ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Last PPD Test: Positive Negative Date: _____
Allergies: _____

Has the patient been treated previously for this condition?
 Yes No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Cimzia	<input type="checkbox"/> 200mg syringe <input type="checkbox"/> 200 mg single-dose vial	<u>Loading Dose:</u> <input type="checkbox"/> Inject 400 mg SC 0,2,4 weeks followed by 200mg every other week <input type="checkbox"/> Inject 400mg SC every other week <input type="checkbox"/> Inject 400mg SC 0, 2, 4 weeks	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 400 mg SC every 4 weeks <input type="checkbox"/> Inject 200 mg SC every other week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other
Cosentyx™ <i>*Enhanced Specialty Pharmacy Program Participant</i>	<input type="checkbox"/> 150mg pen <input type="checkbox"/> 150mg syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 300mg SC 0,1,2,3,4 weeks	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 300mg SC every 4 weeks	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other
Cosentyx™ <i>*Enhanced Specialty Pharmacy Program Participant Covered Until You're Covered</i>	<input type="checkbox"/> 150mg pen <input type="checkbox"/> 150mg syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 300mg SC 0,1,2,3,4 weeks	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 300mg SC every 4 weeks	<input type="checkbox"/> 4 week supply (maintenance) <input type="checkbox"/> 5 week supply (loading) <input type="checkbox"/> Other
Enbrel®	<input type="checkbox"/> 50mg/ml single-use prefilled syringe <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 25mg/0.5ml Prefilled syringe <input type="checkbox"/> 25mg Vial	<u>Loading Dose:</u> <input type="checkbox"/> Inject 50mg SC TWICE a week (72-96 hours apart) for three months then maintenance dosing	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 50mg SC ONCE a week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other
Humira® Psoriasis-Starter Kit	Standard: <input type="checkbox"/> 40mg/0.8ml Pen x4 (Starter Kit) Citrate Free: <input type="checkbox"/> 80mg/0.8ml Pen x1, 40mg/0.4ml Pen x2 (Citrate-Free)	<u>Loading Dose:</u> <input type="checkbox"/> Inject 80 mg SC day 1, 40 mg day 8, 40 mg maintenance beginning on day 22	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Humira®	Standard: <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled SYR Citrate-Free: <input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled SYR (Citrate-Free)	<input type="checkbox"/> Inject 40mg SC every OTHER week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Ilumya	<input type="checkbox"/> 100 mg/ml Prefilled syringe	<u>Loading Dose:</u> <input type="checkbox"/> 100 mg SC at Weeks 0, and 4, then every 12 weeks thereafter	<u>Maintenance Dose:</u> <input type="checkbox"/> 100 mg SC every 12 Weeks	<input type="checkbox"/> _____ Vials <input type="checkbox"/> Other
Inflectra	<input type="checkbox"/> 100 mg Vial	<u>Loading Dose:</u> <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV at 0, 2, and 6 weeks then every 8 weeks thereafter	<u>Maintenance Dose:</u> <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV every 8 Weeks <input type="checkbox"/> IV _____ mg every _____ weeks	<input type="checkbox"/> _____ Vials <input type="checkbox"/> Other
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: _____ Date: _____



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PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:		Quantity:	Refills:
Otezla	<input type="checkbox"/> 28 Day Starter Pack Titration <input type="checkbox"/> 30mg tablet	<u>Induction Dose:</u> <input type="checkbox"/> Titration per starter pack	<u>Maintenance Dose:</u> <input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 1 Month Starter Pack <input type="checkbox"/> Bottle of 60 <input type="checkbox"/> Other	
Otrexup	<input type="checkbox"/> 10 mg/0.4ml <input type="checkbox"/> 17.5 mg/0.4ml <input type="checkbox"/> 12.5 mg/0.4ml <input type="checkbox"/> 20 mg/0.4 ml <input type="checkbox"/> 15 mg/0.4 ml <input type="checkbox"/> <i>Prefilled Autoinjector</i>	<input type="checkbox"/> Inject _____ mg SC once weekly		<input type="checkbox"/> _____ Prefilled Autoinjector(s) <input type="checkbox"/> Other	
Rasuvo	<input type="checkbox"/> 7.5 mg /0.15ml <input type="checkbox"/> 20 mg/0.4ml <input type="checkbox"/> 10 mg/0.2ml <input type="checkbox"/> 22.5 mg/0.45ml <input type="checkbox"/> 12.5 mg /0.25ml <input type="checkbox"/> 25 mg /0.5ml <input type="checkbox"/> <i>Prefilled Autoinjector</i>	<input type="checkbox"/> Inject _____ mg SC once weekly		<input type="checkbox"/> _____ Prefilled Autoinjector(s) <input type="checkbox"/> Other	
Rayos	<input type="checkbox"/> 1 mg Tablet <input type="checkbox"/> 2 mg Tablet <input type="checkbox"/> 5 mg Tablet	<input type="checkbox"/> Take _____ mg by mouth daily		<input type="checkbox"/> _____ Day Supply <input type="checkbox"/> Other	
Remicade	<input type="checkbox"/> 100 mg Vial	<u>Loading Dose:</u> <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV at 0, 2, and 6 weeks then every 8 weeks thereafter	<u>Maintenance Dose:</u> <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV every 8 Weeks <input type="checkbox"/> IV _____ mg every _____ weeks	<input type="checkbox"/> _____ Vials <input type="checkbox"/> Other	
Renflexis	<input type="checkbox"/> 100 mg vial	<u>Loading Dose:</u> <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV at 0, 2, and 6 weeks then every 8 weeks thereafter	<u>Maintenance Dose:</u> <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV every 8 Weeks	<input type="checkbox"/> _____ Vials <input type="checkbox"/> Other	
Siliq	<input type="checkbox"/> 210mg/1.5 ml Prefilled syringe	<input type="checkbox"/> Inject 219 mg SC at weeks 0, 1 and 2 and 210 mg SC every 2 weeks thereafter		<input type="checkbox"/> Starter Dose (3 SYR) <input type="checkbox"/> Maintenance Dose (2 SYR) <input type="checkbox"/> Other	
Stelara	<input type="checkbox"/> 45 mg/ 0.5ml Prefilled syringe <input type="checkbox"/> 90 mg/ml Prefilled syringe	<input type="checkbox"/> Patients weighing 100kg: Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter <input type="checkbox"/> Patients weighing >100kg: Inject 90mg SC at 0 and 4 weeks, then every 12 weeks thereafter		<input type="checkbox"/> 2 SYR loading <input type="checkbox"/> 1 SYR maintenance <input type="checkbox"/> Other	
Taltz	<input type="checkbox"/> 80mg/ml single-dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml single-dose Prefilled syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 160 mg SC at week 0 followed by 80 mg SC on weeks 2,4,6,8, 10 and 12	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 80 mg SC every 4 weeks	<input type="checkbox"/> 3 SYR/Pens <input type="checkbox"/> 2 SYR/Pens <input type="checkbox"/> 1 SYR/Pens <input type="checkbox"/> Other	
Tremfya	<input type="checkbox"/> 100 mg/ml prefilled syringe <input type="checkbox"/> 100 mg/ml autoinjector	<input type="checkbox"/> Inject _____ mg SC at weeks 0, 4, then every 8 weeks thereafter		<input type="checkbox"/> Loading Dose/ 4 week supply <input type="checkbox"/> Maintenance Dose 8 Week Supply <input type="checkbox"/> Other	
Skyrizi	<input type="checkbox"/> 75mg/0.83mL prefilled syringe	<u>Loading Dose:</u> <input type="checkbox"/> Inject 150 mg (2-75mg syringes) SC at weeks 0, 4, and every 12 weeks thereafter	<u>Maintenance Dose:</u> <input type="checkbox"/> Inject 150 mg SC every 12 weeks	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Other					
<input type="checkbox"/> Patient is interested in patient support programs			<input type="checkbox"/> Ancillary supplies provided for administration		

Physician Signature: _____ Date: _____