ENVISIONPHARMACIES

# Psoriatic Arthritis Enrollment Form
**Fax: 877-309-0687 Phone: 877-437-9012**

☐ **New to Therapy**
☐ **Current Therapy**

## Patient Information

Patient Name: _____

Date of Birth: _____ Sex: _____ SS# _____
Address: _____
City: _____State:_____Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Patient: _____
ID# _____Group# _____
RxBIN: _____RxPCN: _____

## Prescriber Information

Practice/ Organization Name: _____
Physician Name: _____
Address: _____
City: _____State: _____Zip: _____
Phone#: _____Fax#: _____
DEA#_____NPI# _____
License#: _____Medicaid UPIN#: _____
Physician Specialty: _____
**Date Shipment Needed: _____**
**Ship to: ☐Patient ☐Prescriber ☐Other**
Shipment Address: _____Attn: _____
City: _____State: _____Zip: _____
*If shipped to the physician's office, physician accepts on behalf of patient for administration in office.*



## Clinical Information and Prescription

Diagnosis: ☐ L40.__ Psoriasis ☐ L40.54 Juvenile Psoriatic Arthritis ☐ L40.59 Psoriatic Arthritis ☐ Other:_____
Date of Diagnosis or Years with Disease: _____ Allergies (☐ NKDA): _____
Patient Weight: _____ Patient Height: _____ NEGATIVE tuberculin skin test? ☐ YES ☐ NO
BSA (Body Surface Area) affected by Psoriasis: _____% Has Hepatitis B been ruled out? ☐ YES ☐ NO
Prior Failed Medications and Date_____
Expected First Dose Date: _____ Injection Instruction needed: ☐YES ☐NO ☐ In-office administration or training

**Psoriatic Arthritis Treatment Selection:**

☐ **Cimzia®** (certolizumab pegol) ☐ Prefilled Syringes OR ☐ Vials ☐ Initial Dose: Inject 400 mg SC at weeks 0,2,4
☐ Inject 200mg SC every other week OR ☐ Inject 400mg SC once every 4 weeks

☐ **Cosentyx®** (secukinumab) ☐ Pen Auto injector OR ☐ Prefilled Syringe ☐ 150 mg OR ☐ 300 mg
☐ Initial: Inject SC at weeks 0,1,2,3,4, then SC every 4 weeks ☐ Maintenance: Inject SC every 4 weeks

☐ **Enbrel®** (etanercept) ☐50mg SureClick ☐50mg Mini AutoTouch ☐50mg PF Syringe ☐25mg PF Syringe ☐25mg Vial
☐ Inject 50mg SC once per week ☐Other:_____

☐ **Humira®** (adalimumab) ☐ 40mg Prefilled Syringe OR ☐ 40mg Pen Auto injector ☐ Requesting citrate/buffer free
☐ Inject 40mg SC every two weeks ☐Other:_____

☐ **Orencia®** (golimumab) Inject 50 mg SC once per month ☐ 50mg/0.5ml Syringe ☐ 50mg/0.5ml SmartJect Auto injector

☐ **Otezla®** (apremilat) ☐ Initial: Take as directed per starter pack ☐ Maintanence: Take 30mg by mouth twice per day

☐ **Remicade®** (infliximab) OR ☐**Inflectra®** (infliximab-dyyb) OR ☐**Renflexis®** (infliximab-abda)
☐ Initial: Infuse 5mg/kg IV infusion at weeks 0,2,6, then 5mg/kg IV infusion every 8 weeks
☐ Maintenance: Infuse 5mg/kg IV infusion every 8 weeks *Must provide patient's weight

☐ **Simponi®** (golimumab) Inject 50 mg SC once per month ☐ Prefilled Syringe ☐ SmartJect Auto injector

☐ **Simponi Aria®** (golimumab) ☐Initial: Infuse 2 mg/kg IV at week 0, 4 then every 8 weeks
☐ Maintenance: Infuse 2mg/kg IV infusion every 8 weeks *Must provide patient's weight

☐ **Stelara®** (ustekinumab) ☐ 45mg Prefilled Syringe (wt<100kg/220 lbs) ☐ 90mg Prefilled Syringe (wt >100kg/220 lbs)
☐ Initial: Inject SC at weeks 0,4, then every 12 weeks thereafter ☐ Maintanence: Inject SC every 12 weeks

☐ **Taltz®** (ixekizumab) ☐ 80mg/ml Prefilled Syringe OR ☐ 80mg/ml Auto injector
☐ Initial: Inject 160 mg SC at week 0, 80 mg SC at weeks 2,4,6,8,10,12 followed by 80mg SC every 4 weeks
☐Maintenance: Inject 80 mg SC every 4 weeks

☐ **Xeljanz®** (tofacitinb) 5 mg PO twice daily

☐ **Xeljanz XR®** (tofacitinib) 11 mg PO once daily

**Quantity Prescribed:**☐QS 30 days ☐Other: ____ **Refills Authorized**:☐ 0 ☐1 ☐2 ☐3 ☐ 6 mo ☐1 yr ☐Other: ___

**Physician Signature (no stamps): _____ Date: _____**