

<input type="checkbox"/> New to Therapy <input type="checkbox"/> 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.

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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

Cimzia® (certolizumab pegol) Prefilled Syringes OR Vials Inject 400 mg SC every other week
 Initial: Inject 400 mg SC initially and at weeks 0, 2 and 4, followed by 200 mg every other week (Wt ≤90 kg)
 Maintenance: Inject 200 mg SC every other week (Wt ≤90 kg)

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
 Initial: Inject 50 mg SC twice per week (3-4 days apart) x 3 months
 Maintenance: Inject 50mg SC once per week Other: _____

Humira® (adalimumab) 40mg Prefilled Syringe OR 40mg Pen Auto injector Requesting citrate/buffer free
 Initial: Inject 80 mg SC Day 1, then 40mg Day 8, then 40mg every other week thereafter
 Maintenance: Inject 40mg SC every two weeks Other: _____

Ilumya® (Tildrakizumab) 100mg/ml Prefilled Syringe
 Initial: Inject SC at weeks 0, 4 and then every 12 weeks thereafter Maintenance: Inject SC every 12 weeks

Otezla® (apremilat) Initial: Take as directed per starter pack Maintenance: Take 30mg by mouth twice daily

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

Siliq® (brodalumab) 210 mg/1.5ml Prefilled Syringe
 Initial: Inject SC at weeks 0,1, and 2 then every 2 weeks thereafter Maintenance: Inject SC every 2 weeks

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

Tremfya® (Guselkumab) 100mg/ml Prefilled Syringe
 Initial: Inject SC at weeks 0, 4 and then every 8 weeks thereafter Maintenance: Inject SC every 8 weeks

Quantity Prescribed: QS 30 days Other: _____ **Refills Authorized:** 0 1 2 3 6 mos 1 yr _____

X _____ / ____ / ____
Physician Signature (no stamps) **Date**