



Patient Information: Name: _____ DOB: _____ Gender: M F
 Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alt. Phone: _____
 Email: _____ Ht: _____ Wt: _____ Care Giver: _____ Allergies: No Known See Attached Charts

Prescriber Information: Name: _____ Address: _____ City: _____ State: _____
 Zip: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ Other: _____ TB Test: Positive Negative Date: _____
 LFT: ALT: _____ AST: _____ Date: _____ Assessment: Moderate Mod to Severe Severe _____% BSA Affected
 Scalp Face Chest Arms Hands Nails Back Groin Buttocks Legs Other _____

Patient also taking methotrexate? Yes No
 Serious or active infection present? Yes No
 Hep B ruled out or treatment started? Yes No
 Does patient have latex allergy? Yes No

Prior Failed Treatments	Length of Treatment
<input type="radio"/> Topicals	
<input type="radio"/> Methotrexate	
<input type="radio"/> Oral Meds	
<input type="radio"/> Biologics	
<input type="radio"/> UVA <input type="radio"/> UVB	
<input type="radio"/> Others	

Injection Training: Pharmacist to Provide Training
 To be Administered by a Healthcare Provider
 Patient Trained in MD Office Manufacturer Nurse Support

Product Delivery: Patient's Home Physician's Office Pharmacy to Coordinate

Prescription Information

Medication	Dosage & Strength	Direction	Qty	Ref
<input type="radio"/> Rasuvo	<input type="radio"/> _____	<input type="radio"/> _____		
<input type="radio"/> Siliq	<input type="radio"/> 210mg/1.5ml Prefilled Syringe	<input type="radio"/> Induction Dose: Inject 210mg subcutaneously at weeks 0,1, and 2 <input type="radio"/> Maintenance Dose: Inject 210mg subcutaneously every 2 weeks	1Month 2Months 3Months	
<input type="radio"/> Simponi	<input type="radio"/> 50mg/0.5ml Smartject Injector <input type="radio"/> 50mg/0.5ml Prefilled Syringe	Inject 50mg SC once a month	1	
<input type="radio"/> Skyrizi	<input type="radio"/> 150mg/ml Prefilled Syringe <input type="radio"/> 150mg/ml Auto Injector <i>Skyrizi Self-Injection: Healthcare provider certifies that patient has been trained and is eligible for self-injection</i>	<input type="radio"/> Induction Dose: Inject 150mg SC at weeks 0 and 4	2	0
		<input type="radio"/> Maintenance Dose: Inject 150mg SC every 12 weeks thereafter	1	
<input type="radio"/> Stelara	<input type="radio"/> 45mg/ml Single-Dose Vial <input type="radio"/> 45mg/ml Prefilled Syringe (for <220lb) <input type="radio"/> 90mg/1ml Prefilled Syringe (for >220lb) <input type="radio"/> Yes <input type="radio"/> No Stelara Self-Injection: <i>Healthcare provider has certified that patient has been trained and is eligible for self-injection</i>	Induction Dose: To achieve pediatric dose <input type="radio"/> <60kg: Inject 0.75mg/kg <input type="radio"/> 60kg-100kg: Inject 45mg/kg <input type="radio"/> >100kg: Inject 90mg/kg <input type="radio"/> Inject the contents of 1 Prefilled Syringe SC on day 1		0
			1	0
		<input type="radio"/> Maintenance Dose: Inject the contents of 1 Prefilled Syringe SC on day 29 and every 12 weeks thereafter	1	
<input type="radio"/> Taltz	<input type="radio"/> 80mg/ml Single-Dose Prefilled Autoinjector <input type="radio"/> 80mg/ml Single-Dose Prefilled Syringe	<input type="radio"/> Weeks 0-2: Inject 160mg (two 80mg injections) at week 0, then inject 80mg SC at week 2	3	0
		<input type="radio"/> Weeks 4-10: Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	2	1
		<input type="radio"/> Week 12 and onward: Inject 80mg SC at week 12 and every 4 weeks thereafter	1	
<input type="radio"/> Tremfya	<input type="radio"/> 100mg/ml Prefilled Syringe <input type="radio"/> 100mg/ml One-Press Patient Controlled Injector	<input type="radio"/> Induction Dose: Inject 100mg/ml SC at weeks 0 and 4	2	
		<input type="radio"/> Maintenance: Inject 100mg/ml SC every 8 weeks thereafter	1	
<input type="radio"/> Xeljanz	<input type="radio"/> 5mg Tablet	<input type="radio"/> Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
<input type="radio"/> Xeljanz XR	<input type="radio"/> 11mg Tablet	<input type="radio"/> Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	
<input type="radio"/> _____	<input type="radio"/> _____	<input type="radio"/> _____		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature _____ Date: _____
Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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