



Patient Information: Name: _____ DOB: _____ Gender: M F Last 4 of SSN: _____
 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"/> Cimzia	<input type="radio"/> 200mg/ml Prefilled Syringe <input type="radio"/> 200mg Lyophilized Powder Vial	<input type="radio"/> Inject 400mg SC every other week <input type="radio"/> Induction Dose: (Weight <90kg) Inject 400mg SC every other week initially and at weeks 2 and 4 <input type="radio"/> Maintenance Dose: (Weight <90kg) Inject 200mg SC every other week		
<input type="radio"/> Cosentyx	<input type="radio"/> 150mg/ml Sensoready Pen <input type="radio"/> 150mg/ml Prefilled Syringe <input type="radio"/> 150mg/ml Lyophilized Powder Vial	<input type="radio"/> Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4 <input type="radio"/> Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4 <input type="radio"/> Maintenance Dose: Inject 150mg SC every four weeks <input type="radio"/> Maintenance Dose: Inject 300mg SC every four weeks	5 10 1 2	0 0
<input type="radio"/> Enbrel	<input type="radio"/> 50mg/ml Sureclick Autoinjector <input type="radio"/> 50mg/ml Prefilled Syringe <input type="radio"/> 25mg Lyophilized Powder Multiple Dose Vial <input type="radio"/> Other: _____	<input type="radio"/> Induction Dose: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing <input type="radio"/> Maintenance: Inject 50mg SC once a week Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder <input type="radio"/> > 138lbs or more: Inject 50mg weekly <input type="radio"/> < 138lbs: Inject 0.8mg/kg weekly <input type="radio"/> Other: _____	8 4 4	2
<input type="radio"/> Humira	<input type="radio"/> Psoriasis Starter Package <input type="radio"/> 80mg/0.8ml Pen <input type="radio"/> 40mg/0.4ml Pen <input type="radio"/> 40mg/0.4ml Prefilled Syringe <input type="radio"/> 40mg/0.8ml Pen <input type="radio"/> 40mg/0.8ml Prefilled Syringe <input type="radio"/> Hidradenitis Suppurativa Starter Package 80mg/0.8ml Pen <input type="radio"/> 40mg/0.4ml Pen <input type="radio"/> 40mg/0.4ml Prefilled Syringe <input type="radio"/> 40mg/0.8ml Pen <input type="radio"/> 40mg/0.8ml Prefilled Syringe	<input type="radio"/> Induction Dose: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week <input type="radio"/> Maintenance: Inject 40mg SC every other week <input type="radio"/> Other: _____ <input type="radio"/> Induction Dose: <input type="radio"/> Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="radio"/> Inject one 80mg pen SC on day 1, one 80mg pen on day 2, then one 80mg pen on day 15 <input type="radio"/> Maintenance: Inject 40mg SC on day 29 and every week thereafter <i>Patient has signed HUMIRA Complete form</i>	3 2 3 4	0 0 0
<input type="radio"/> Orencia	<input type="radio"/> 125mg/ml ClickJectTM Autoinjector <input type="radio"/> 125mg/ml Prefilled Syringe	<input type="radio"/> Inject 125mg SC once a week	4	
<input type="radio"/> Otezla	<input type="radio"/> Starter Pack (Titration) <input type="radio"/> 30mg Tablets	<input type="radio"/> Starter Pack: Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack <input type="radio"/> Maintenance: Take one 30mg tablet by mouth twice daily	1 60	0
<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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