

**PATIENT INFORMATION**

(Complete the following or send patient demographic sheet.)

Please fax copy of patient's insurance card including both sides

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender: M / F Height: \_\_\_\_\_ Wt: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Last 4 digits SS#: \_\_\_\_\_ Email: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 State Lic. #: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY**

Diagnosis:  L40.8 Moderate to Severe Plaque Psoriasis  L40.50 Psoriatic Arthritis  L73.2 Hidradenitis Suppurativa  Other: \_\_\_\_\_  
 Severity of Psoriasis:  Mild (up to 3 % BSA)  Moderate (3 – 10% BSA)  Severe (>10% BSA) BSA % : \_\_\_\_\_  
 Location:  Hands  Feet  Scalp  Groin  Nails  Other \_\_\_\_\_  
 Prior Failed Meds:  Methotrexate Length of Treatment \_\_\_\_\_ Reason for Discontinuing \_\_\_\_\_  
 PUVA/UVB Length of Treatment \_\_\_\_\_ Reason for Discontinuing \_\_\_\_\_  
 Topicals Length of Treatment \_\_\_\_\_ List Specific Meds \_\_\_\_\_  
 Other Length of Treatment \_\_\_\_\_ List Specific Meds \_\_\_\_\_  
 TB/PPD Test given?  Yes  No Results \_\_\_\_\_ Date \_\_\_\_\_ Allergies \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication	Directions	Quantity	Refills	
<b>Cosentyx®</b>	<input type="checkbox"/> 150mg Sensoready Pen	Initial Dose: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150 mg SC week 0,1,2,3,4	28 day supply	0
	<input type="checkbox"/> 150mg Prefilled Syringe	Maintenance Dose: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC every 4 weeks	28 day supply	
<b>Cimzia®</b>	<input type="checkbox"/> 200mg Starter Kit	<input type="checkbox"/> Initial Dose: Inject 400 mg SC at weeks 0, 2, & 4		
	<input type="checkbox"/> 200mg PFS Kit <input type="checkbox"/> 200mg Vial Kit	<input type="checkbox"/> Maintenance: Inject 400 mg SC Q2wks <input type="checkbox"/> Maintenance: Inject 200 mg SC Q2wks		
<b>Dupixent®</b>	<input type="checkbox"/> 300mg/2ml Prefilled Pen	<b>Adults:</b> <input type="checkbox"/> 600 mg (two 300 mg injections) followed by 300 mg Q2W	28 day supply	
	<input type="checkbox"/> 300mg/2mL Prefilled Syringe	<b>Pediatric Patients:</b>		
<b>Enbrel®</b>	<input type="checkbox"/> 200mg/1.14mL Prefilled Syringe	<b>Body Weight Initial Dose Subsequent Doses</b>		
	<input type="checkbox"/> 50 mg Sureclick Autoinjector <input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 50 mg mini <input type="checkbox"/> 25 mg PFS <input type="checkbox"/> 25 mg Vials	<input type="checkbox"/> 15 to less than 30 kg 600 mg (two 300 mg injections) <input type="checkbox"/> 30 to less than 60 kg 400 mg (two 200 mg injections) <input type="checkbox"/> 60 kg or more 600 mg (two 300 mg injections)	300 mg Q4wks 200 mg Q2wks 300 mg Q2wks	
<b>Humira®</b>	<input type="checkbox"/> Psoriasis Starter Kit	<input type="checkbox"/> Inject SC twice a week 72 - 96 hours apart <input type="checkbox"/> Inject SC once a week	1 starter kit	
	<input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg PFS <input type="checkbox"/> Psoriasis Starter Kit CF <input type="checkbox"/> 40 mg CF Pen <input type="checkbox"/> 40 mg CF PFS	<input type="checkbox"/> Inject _____ mg (0.8mg/kg X _____ kg SC every week (≤ 63 kg) <input type="checkbox"/> Other:	28 day supply	
<b>Humira® HS</b>	<input type="checkbox"/> HS Starter Kit <input type="checkbox"/> 40 mg Pen	<input type="checkbox"/> Initial Dose: Inject 80 mg SC on day 1, 40 mg on day 8, then maintenance dose every other week thereafter	1 starter kit	
	<input type="checkbox"/> 40 mg PFS <input type="checkbox"/> HS Starter Kit CF <input type="checkbox"/> 40 mg CF Pen <input type="checkbox"/> 40 mg CF PFS <input type="checkbox"/> 80 mg CF Pen	<input type="checkbox"/> Maintenance Dose: Inject 40 mg SC every other week	28 day supply	
<b>Ilumya™</b>	<input type="checkbox"/> HS Starter Kit <input type="checkbox"/> 40 mg Pen	<input type="checkbox"/> Initial Dose: Inject 160 mg SC on day 1, 80mg on day 15, then 40mg every week beginning on day 29	1 starter kit	
	<input type="checkbox"/> 40 mg PFS <input type="checkbox"/> HS Starter Kit CF <input type="checkbox"/> 40 mg CF Pen <input type="checkbox"/> 40 mg CF PFS <input type="checkbox"/> 80 mg CF Pen	<input type="checkbox"/> Maintenance Dose: (At week 4) Inject 40mg SQ weekly <input type="checkbox"/> Inject 80mg every other week	28 day supply	
<b>Otezla®</b>	<input type="checkbox"/> 100 mg/mL PFS	<input type="checkbox"/> Initial Dose: Inject 100 mg SC at week 0 & 4	2	0
	<input type="checkbox"/> Titration Starter Pack <input type="checkbox"/> 30 mg Tablets	<input type="checkbox"/> Maintenance: Inject 100 mg SC Q12wks	1	
<b>Rinvoq™</b>	<input type="checkbox"/> 15 mg ER tablet	<input type="checkbox"/> Initial Dose: Titrate as directed on package	1 starter pack	0
	<input type="checkbox"/> 30 mg ER tablet	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth twice daily	30 day supply	
<b>Simponi®</b>	<input type="checkbox"/> 15 mg ER tablet <input type="checkbox"/> 30 mg ER tablet	<input type="checkbox"/> Take one (15mg) tablet PO once daily <input type="checkbox"/> Take one (30mg) tablet PO once daily <input type="checkbox"/> Other:	30 day supply	
	<input type="checkbox"/> 50 mg SmartJect <input type="checkbox"/> 50 mg PFS	<input type="checkbox"/> Inject 50 mg SC once a month as directed	28 day supply	
<b>Stelara®</b>	<input type="checkbox"/> 50 mg SmartJect <input type="checkbox"/> 50 mg PFS	<input type="checkbox"/> Inject 50 mg SC once a month as directed	28 day supply	
	<input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe	<input type="checkbox"/> (< 220 lbs) Inject 45 mg on day 0 then week 4, followed by 45 mg dose every 12 weeks <input type="checkbox"/> (> 220 lbs) Inject 90 mg on day 0 then week 4, followed by 90 mg dose every 12 weeks	28 day supply	
<b>Skyrizi®</b>	<input type="checkbox"/> 75 mg 2 PFS Kit	<input type="checkbox"/> Initial Dose: Inject 150 mg SQ on week 0 & 4	1	0
	<input type="checkbox"/> 150 mg Pen <input type="checkbox"/> 150 mg PFS	<input type="checkbox"/> Maintenance: Inject 150 mg SQ Q12wk	1	
<b>Taltz®</b>	<input type="checkbox"/> 80 mg Autoinjector Pen	<input type="checkbox"/> Initial Dose: Inject 160 mg SC at week 0 then 80 mg at weeks 2,4,6,8,10 and 12	28 day supply	2
	<input type="checkbox"/> 80 mg Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 80 mg SC every 4 weeks	28 day supply	
<b>Tremfya™</b>	<input type="checkbox"/> 80 mg Autoinjector Pen	<input type="checkbox"/> Initial Dose: Inject 100 mg SC at week 0 & 4	2	0
	<input type="checkbox"/> 80 mg Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 100 mg SC Q8wks	1	
<input type="checkbox"/> Other				

Ship Medications To:  Physician's Clinic  Patient's Home

Injection Training Needed:  Yes  No

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Brand Name Required?  Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.