

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ Patient also taking Methotrexate? Yes No
 ICD-10: _____ Other: _____ Serious or active infection present? Yes No
 TB Test: Positive Negative Date: _____ Hep B ruled out or treatment started? Yes No
 LFT: ALT: _____ AST: _____ Date: _____ Does patient have latex allergy? Yes No
 Assessment: Moderate Mod to Severe Severe
 _____% BSA affected
 Scalp Face Chest Arms Hands Nails
 Back Groin Buttocks Legs Other: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:

Topicals _____
 Methotrexate _____
 Oral Meds _____
 Biologics _____
 UVA UVB _____
 Others _____

4 INJECTION TRAINING: To Be Administered by Pharmacist Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> RASUVO®	<input type="checkbox"/> _____ <input type="checkbox"/> _____			
<input type="checkbox"/> SIMPONI® (for PsA)	<input type="checkbox"/> 50mg/0.5ml Smartject Injector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45mg/ml Single-Dose Vial	Induction Dose: To achieve pediatric dose: <input type="checkbox"/> < 60kg: Inject 0.75mg/kg <input type="checkbox"/> 60kg - 100kg: Inject 45mg SC <input type="checkbox"/> > 100kg: Inject 90mg SC		0
	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs)	<input type="checkbox"/> Inject the contents of 1 prefilled syringe SC on day 1	1	0
	<input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs)	Maintenance: Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter <input type="checkbox"/> Yes or <input type="checkbox"/> No: <i>STELARA SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection</i>	1	
<input type="checkbox"/> TALTZ®	<input type="checkbox"/> 80mg/ml Single-Dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml Single-Dose Prefilled Syringe	Induction Dose: Inject 160mg SC (two 80mg injections) at weeks 0 then 80mg SC at weeks 2, 4, 6, 8, 10 and 12	8	0
		Maintenance: Inject 80mg subcutaneously every 4 weeks	1	
<input type="checkbox"/> TREMFYA™	<input type="checkbox"/> 100mg/ml Prefilled Syringe	Induction Dose: Inject 100mg/ml SC at weeks 0 and 4	2	0
		Maintenance: Inject 100mg/ml SC every 8 weeks thereafter	1	
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablet	Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
		Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	
<input type="checkbox"/>				

Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia™ and Otezla® are listed alphabetically on respective enrollment forms.

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ 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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