

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: _____
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
Does patient have joint involvement? Yes No
If yes, please indicate affected joint(s): _____

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 a Healthcare Provider 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®	Single-dose auto-injector prefilled syringe: <input type="checkbox"/> 7.5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 12.5mg <input type="checkbox"/> 15mg <input type="checkbox"/> 17.5mg <input type="checkbox"/> 20mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 25mg <input type="checkbox"/> 27.5mg <input type="checkbox"/> 30mg	<input type="checkbox"/> Inject _____ mg SC once weekly *An initial test dose of 2.5 to 5 mg is recommended in patients with risk factors for hematologic toxicity or renal impairment*		
<input type="checkbox"/> RINVOQ®	<input type="checkbox"/> 15mg ER Tablets	<input type="checkbox"/> Take 15mg tablet once daily	30	
<input type="checkbox"/> SILIQ®	<input type="checkbox"/> 210mg/1.5ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 210mg subcutaneously at Weeks 0, 1 and 2 <input type="checkbox"/> Maintenance Dose: Inject 210mg subcutaneously every 2 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months	
<input type="checkbox"/> SIMPONI® (for PSA)	<input type="checkbox"/> 50mg/0.5ml prefilled syringe <input type="checkbox"/> 50mg/0.5ml prefilled SmartJect® autoinjector	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> SKYRIZI®	<input type="checkbox"/> 150mg/ml in each single-dose prefilled pen <input type="checkbox"/> 150mg/ml in each single-dose prefilled syringe <input type="checkbox"/> Yes or <input type="checkbox"/> No: SKYRIZI SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection	<input type="checkbox"/> Induction Dose: Inject 150mg SC at weeks 0 and week 4 <input type="checkbox"/> Maintenance Dose: Inject 150mg SC every 12 weeks thereafter	2 1	
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45mg/0.5 ml Single-Dose Prefilled Syringe <input type="checkbox"/> 45mg/0.5 ml Solution in a Single-Dose Vial <input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 100 kg)	Plaque Psoriasis: <input type="checkbox"/> Adult Dosing (≤100 kg): Inject 45 mg SC initially and at 4 weeks, then every 12 weeks thereafter <input type="checkbox"/> Adult Dosing (>100 kg): Inject 90 mg SC initially and at 4 weeks, then every 12 weeks thereafter Psoriatic Arthritis: <input type="checkbox"/> Inject 45 mg SC initiation and at 4 weeks, then every 12 weeks thereafter 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 Psoriatic Arthritis: Co-existent moderate-to-severe plaque psoriasis weighing <input type="checkbox"/> >100 kg: Inject 90 mg SC initially and at 4 weeks, then every 12 weeks thereafter		
<input type="checkbox"/> TALTZ®	<input type="checkbox"/> 80mg/ml Single-Dose Prefilled Autoinjector <input type="checkbox"/> 80mg/ml Single-Dose Prefilled Syringe	Psoriatic Arthritis (PsA): <input type="checkbox"/> Induction Dose: Inject 160 mg SC (two 80 mg injections) at week 0 <input type="checkbox"/> Maintenance: Inject 80 mg SC every 4 weeks thereafter Plaque Psoriasis or PsA with Coexistent Moderate-to-Severe Plaque Psoriasis: <input type="checkbox"/> Weeks 0-2: Inject 160mg SC (two 80mg injections) at weeks 0, then inject 80mg SC at week 2 <input type="checkbox"/> Weeks 4-10: Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10 <input type="checkbox"/> Week 12 and onwards: Inject 80mg SC at week 12 and every 4 weeks thereafter	3 4	0 0
<input type="checkbox"/> TREMFYA®	<input type="checkbox"/> 100mg/ml Prefilled Syringe <input type="checkbox"/> 100mg/ml One- Press Patient Controlled Injector	<input type="checkbox"/> Induction Dose: Inject 100mg/ml SC at weeks 0 and 4 <input type="checkbox"/> Maintenance: Inject 100mg/ml SC every 8 weeks thereafter	2 1	0
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablet	<input type="checkbox"/> Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
<input type="checkbox"/> XELJANZ® XR	<input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	

Cimzia®, Cosentyx®, Enbrel®, Humira®, Orenia® 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. If Prescribing SILIQ®: I certify that I made the prescribing decisions indicated above based on my own independent medical judgment regarding what is in the best interest of the patient and that I have reviewed the current SILIQ Prescribing Information. By signing above, I confirm that: (1) I am certified as a healthcare provider under the SILIQ REMS Program, (2) I have counseled the patient on the risks of suicidal ideation and behavior that may occur with SILIQ, (3) the patient has signed the SILIQ REMS Patient-Prescriber Agreement, (4) I have given the patient the SILIQ REMS patient wallet card, and (5) I have enrolled the patient in the SILIQ REMS Program. I authorize SILIQ Solutions to act on my behalf to transmit this prescription to the appropriate qualified pharmacy designated above by the patient or the patient's plan.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.