

## 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  
 Hands  Scalp  Feet  Groin  Nails

**If Prior Authorization is Denied:**  
 Automatically Draft Appeal for Review  
 Send Preferred Formulary Alternatives

**Prior Failed Treatments:** **Indicate Drug Name and Length of Treatment:**

Topicals \_\_\_\_\_  
 Methotrexate \_\_\_\_\_  
 Oral Meds \_\_\_\_\_  
 Biologics \_\_\_\_\_  
 UVA  UVB \_\_\_\_\_  
 Others \_\_\_\_\_

## 4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

## 5 PRODUCT DELIVERY: Patient's Home 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"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector	<input type="checkbox"/> <b>Induction Dose:</b> Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
	<input type="checkbox"/> 50mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Maintenance:</b> Inject 50mg SC once a week	4	
	<input type="checkbox"/> 25mg Lyophilized Powder Multiple Dose Vial	<input type="checkbox"/> <b>Pediatric Patients:</b> To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder	4	
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> 25mg Lyophilized Powder Multiple Dose Vial	<input type="checkbox"/> > 138lbs or more: Inject 50mg weekly		
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> < 138lbs: Inject 0.8mg/kg weekly		
	<input type="checkbox"/> Psoriasis Starter Package	<input type="checkbox"/> <b>Induction Dose:</b> Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	4	0
	<input type="checkbox"/> 40mg/0.8ml Pen	<input type="checkbox"/> <b>Maintenance:</b> Inject 40mg SC every other week	2	
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Hidradenitis Suppurativa Starter Package	<input type="checkbox"/> <b>Induction Dose:</b> Inject 160mg SC on day 1 (or 80mg on day 1 and 80mg on day 2), then 80mg SC on day 15, then switch to maintenance dose on day 29	6	0
	<input type="checkbox"/> 40mg/0.8ml Pen	<input type="checkbox"/> <b>Maintenance:</b> Inject 40mg SC every week	4	
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Patient has signed HUMIRA Complete form		
	<input type="checkbox"/> ORENCIA®	<input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector	4	
<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 125mg SC once a week		
	<input type="checkbox"/> Starter Pack (Titration)	<input type="checkbox"/> <b>Starter Pack:</b> 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	1	0
	<input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> <b>Maintenance:</b> Take one 30mg tablet by mouth twice daily	60	
<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"/> Inject 50mg SC once a month	1	
	<input type="checkbox"/> 50mg/0.5ml Prefilled Syringe			
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs)	<input type="checkbox"/> <b>Induction Dose:</b> Inject the contents of 1 prefilled syringe SC on day 1	1	0
	<input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs)	<input type="checkbox"/> <b>Maintenance:</b> Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1	
	<input type="checkbox"/> Yes or <input type="checkbox"/> No: STELARA SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection			
<input type="checkbox"/> TREMFYA™	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Induction Dose:</b> Inject 100mg/ml SC at weeks 0 and 4	2	0
		<input type="checkbox"/> <b>Maintenance:</b> Inject 100mg/ml SC every 8 weeks thereafter	1	
<input type="checkbox"/>				

### 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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