

# Psoriasis PRESCRIPTION & ENROLLMENT FORM

## 1 PATIENT INFORMATION

Patient's name \_\_\_\_\_  
Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
Street address \_\_\_\_\_ Apt# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/guardian (if applicable) \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Insurance company name \_\_\_\_\_  
Insurance company phone # \_\_\_\_\_  
Insured's name \_\_\_\_\_  
Insured's employer \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
Prescription card  No  Yes If Yes, carrier \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Is patient eligible for Medicare?  No  Yes **Please attach front and back copy of patient's insurance cards, if available.**

## 2 PRESCRIBER INFORMATION

**All fields must be completed to expedite prescription fulfillment.**

Date \_\_\_\_\_ Time \_\_\_\_\_  
Prescriber's name and title \_\_\_\_\_  
Office contact \_\_\_\_\_  
Clinic / hospital affiliation \_\_\_\_\_  
Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
NPI # \_\_\_\_\_ License # \_\_\_\_\_  
DEA # \_\_\_\_\_  
Physician Medicaid UPIN # \_\_\_\_\_  
MD specialty \_\_\_\_\_

To reach your team, call toll-free 1 888 608-9010.

**Please fax completed form to the Psoriasis team at 1 866 898-0114.**

Amevive is a registered trademark of Astellas Pharma US, Inc.  
Enbrel is a registered trademark of Immunex Corporation.  
Humira is a registered trademark of Abbott Laboratories.  
Remicade is a registered trademark of Centocor Ortho Biotech Inc.  
Stelara is a registered trademark of Centocor Ortho Biotech Inc.  
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## 3 CLINICAL INFORMATION

New patient  Current

Primary ICD-9 Code: \_\_\_\_\_

Severity:  Moderate  Moderate to severe  Severe  BSA \_\_\_\_\_%

Type:  Plaque Other \_\_\_\_\_

Significant symptoms: \_\_\_\_\_

Prior Treatments:  Topicals  PUVA  UVB

Methotrexate  Cyclosporine  Oral retinoids Other \_\_\_\_\_

NKDA  Known drug allergies: \_\_\_\_\_

Medical justification for prescribing: \_\_\_\_\_

## 4 PRESCRIBING INFORMATION

**Amevive**<sup>®</sup> (alefacept)  
Sig:  Give 7.5mg IV bolus weekly  Inject 15mg IM weekly

**Enbrel**<sup>®</sup> (etanercept)  
Dose:  25mg prefilled syringe  25mg multiuse vial  
 50mg prefilled syringe  50mg Sureclick<sup>™</sup>  
Sig:  Inject 50 mg subcutaneously once a week  
 Inject 50 mg subcutaneously twice a week x 3 months, then 50 mg once a week  
 Inject \_\_\_\_\_ mg subcutaneously \_\_\_\_\_ per week

**Humira**<sup>®</sup> (adalimumab)  
Dose:  40mg/0.8mL PFS  40mg/0.8mL Pens  
Sig:  If new, inject 80mg initial dose, followed by 40 mg every other week starting one week after initial dose.  
 If continuing therapy, inject 40mg subcutaneously every other week.

**Remicade**<sup>®</sup> (infliximab)  
 Infuse in NS 250ml over 2 hours as directed patient weight \_\_\_\_\_ (kg) = \_\_\_\_\_ (mg)  
Dose:  For new start, give 5mg per kg @ 0, 2 & 6 weeks  
 For continuing therapy, give 5 mg per kg every 8 weeks

**Stelara**<sup>®</sup> (ustekinumab)  
Dose:  45mg/0.5mL PFS  90mg/1mL PFS

**For patients <100kg, administer:**  
 Initial dose of 45 mg SC at week 0 and week 4 followed by:  
 Maintenance dose of 45 mg SC every 12 weeks

**For patients >100kg, administer:**  
 Initial dose of 90 mg SC at week 0 and week 4 followed by:  
 Maintenance dose of 90 mg SC every 12 weeks

If shipped to physician's office, physician accepts on behalf of patient for administration in office  
Deliver product to:  Office  Patient's home  Clinic  Clinic location

Dispense:  1 month supply  3 months supply Refill \_\_\_\_\_ times

By signing below, I certify that the above therapy is medically necessary.

Prescriber's printed name \_\_\_\_\_

Prescriber's signature (sign below) \_\_\_\_\_ Date \_\_\_\_\_

**Dispense as written** **Substitution allowed**  
(Physician attests this is his/her legal signature. **NO STAMPS**)