

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
1 866 898-0114.

*accredo*SM
a medco company

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® (alefacept)

Sig: Give 7.5mg IV bolus weekly

Inject 15mg IM weekly

Enbrel® (etanersept)

Dose: 25mg prefilled syringe

25mg multiuse vial

50mg prefilled syringe

50mg Sureclick™

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® (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® (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

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)