Please fax both pages of completed form to the Psoriasis team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form
Psoriasis

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient
Patient's first name _____ Last name _____ Middle initial _____
☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____
Street address _____ Apt # _____
City _____ State _____ Zip _____
Home phone _____ Cell phone _____ E-mail address _____
Parent/guardian (if applicable) _____
Home phone _____ Cell phone _____ E-mail address _____
Alternate caregiver/contact _____
Home phone _____ Cell phone _____ E-mail address _____
☐ OK to leave message with alternate caregiver/contact
Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
Prescriber info: Prescriber's first name _____ Last name _____
Prescriber's title _____ If NP or PA, under direction of Dr. _____
Office phone _____ Fax _____ NPI # _____ License # _____
Office contact and title _____ Office contact e-mail _____
Office street address _____ Suite # _____
City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Influsion site If infusion site, complete information below:
Infusion info: Infusion site name _____ Clinic/hospital affiliation _____
Site street address _____ Suite # _____
City _____ State _____ Zip _____
Infusion clinic contact name _____ Phone _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Severity: ☐ Moderate ☐ Moderate to severe ☐ Severe ☐ BSA _____%
Type: ☐ Plaque ☐ Other _____
Significant symptoms _____
Prior Treatments: ☐ Topicals ☐ PUVA ☐ UVB ☐ Methotrexate ☐ Cyclosporine ☐ Oral retinolds ☐ Other _____
Medical justification for prescribing _____
☐ NKDA ☐ Known drug allergies _____
Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
☐ Cimzia® (certolizumab)	**Starter:** ☐ 200mg/mL solution in a single-dose PFS Starter Kit ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	☐ Inject 400mg subcutaneously at weeks 0, 2 and 4.	1 STARTER KIT -OR- QS for 1 month loading dose
	Maintenance: ☐ 200mg/mL solution in a single-dose prefilled syringe (PFS) ☐ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	☐ Inject 400mg subcutaneously every 2 weeks. ☐ Inject 200mg subcutaneously every 2 weeks. ☐ Other _____	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Cosentyx® (secukinumab)	☐ 75mg Syringe ☐ 150mg ☐ 300mg (Each 300mg dose is given as 2 subcutaneous injections of 150mg). ☐ Prefilled Syringe ☐ Pen	**Loading dose:** ☐ Inject _____mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by _____every 4 weeks.	QS for 5 doses
		Maintenance dose: ☐ Inject _____mg subcutaneously every 4 weeks.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Enbrel® (etanercept)	☐ 25mg Single Use vial ☐ 25mg PFS ☐ 50mg PFS ☐ 50mg SureClick™ ☐ 50mg Mini Cartridge	**Loading dose:** ☐ Inject 50mg subcutaneously twice a week x 3 months, then 50mg once a week.	QS for 3 month loading dose
		Maintenance dose: ☐ Inject 50mg subcutaneously once a week. ☐ Inject _____mg subcutaneously _____per week.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Humira® (adalimumab)	**Starter:** ☐ 80mg/0.8mL and 40mg/0.4mL citrate-free pens starter package ☐ 40mg/0.8 mL pens starter kit ☐ 40mg /0.4 mL prefilled syringes for starter dose	☐ Inject 80mg subcutaneously on day 1, then inject 40mg on day 8 and every other week thereafter.	1 STARTER KIT -OR- QS for 1 month loading dose
	Maintenance: ☐ 40mg/0.4mL citrate-free pen ☐ 40mg/0.4mL citrate-free PFS ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL PFS	☐ Inject 40mg subcutaneously every other week.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Ilumya™ (tildrakizumab-asmn)	100mg/mL in a single-dose PFS	**Loading dose:** ☐ Inject 100mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter.	2 syringes for loading/ induction dose
		Maintenance dose: ☐ Inject 100mg subcutaneously every 12 weeks.	☐ 3-month supply ☐ Other _____ Refills _____
☐ Other _____			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
☐ Otezla® (apremilast)	**Starter:** ☐ Starter Pack (28 day)	Day 1: Take by mouth 10mg in the morning. Day 2: Take by mouth 10mg in the morning and 10mg in the evening. Day 3: Take by mouth 10mg in the morning and 20mg in the evening. Day 4: Take by mouth 20mg in the morning and 20mg in the evening. Day 5: Take by mouth 20mg in the morning and 30mg in the evening. Day 6 and thereafter: Take by mouth 30mg in the morning and 30mg in the evening.	1 Kit
	Maintenance: ☐ 30mg tablets	☐ Take 30mg by mouth twice a day. ☐ Take 30mg by mouth once a day (severe renal impairment).	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Siliq™ (brodalumab)	210mg/1.5mL prefilled syringe (PFS) (2-pack)	**Loading dose:** ☐ Inject 210mg subcutaneously at weeks 0, 1 and 2 followed by 210mg every 2 weeks.	2 KIT
		Maintenance dose: ☐ Inject 210mg subcutaneously every 2 weeks.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Skyrizi™ (risankizumab-rzaa)	☐ 150mg/mL in each single-dose PFS ☐ 150mg/mL in each single-dose pen	**Loading dose:** ☐ Inject 150mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter.	2 doses for loading/ induction
		Maintenance dose: ☐ Inject 150mg subcutaneously every 12 weeks.	☐ 3-month supply ☐ Other _____ Refills _____
☐ Stelara® (ustekinumab)	☐ 45mg/0.5mL single-dose vial ☐ 45mg/0.5mL PFS ☐ 90mg/1mL PFS **Please include patient weight: _____ kg	**Loading dose:** ☐ Inject _____ mg subcutaneously at week 0 and week 4, followed by every 12 weeks thereafter	2 doses for loading/ induction
		Maintenance dose: ☐ Inject _____ mg subcutaneously every 12 weeks	☐ 3-month supply ☐ Other _____ Refills _____
☐ Taltz® (ixekizumab)	☐ 80mg single-dose autoinjector ☐ 80mg single-dose PFS	**Loading and Induction dose:** ☐ Inject 160mg (two 80mg injections) subcutaneously at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, then 80mg every 4 weeks.	8 devices for loading/ induction
		Maintenance dose: ☐ Inject 80mg subcutaneously every 4 weeks	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Tremfya™ (guselkumab)	☐ 100mg/mL in each single-dose PFS ☐ 100mg/mL in each single-dose pen	**Loading dose:** ☐ Inject 100mg subcutaneously at weeks 0, 4 and every 8 weeks thereafter.	2 doses for loading/ induction
		Maintenance dose: ☐ Inject 100mg subcutaneously every 8 weeks.	☐ 2-month supply ☐ Other _____ Refills _____
☐ Other _____			
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE _____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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