Please fax both pages of completed form to the Psoriasis team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

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 (a-i)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's 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's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Infusion clinic name _____ Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to ❑ Office ❑ Patient's home ❑ Clinic Clinic location _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code: _____ 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

***Provide address for the selected shipment option.**
Check Unknown if assistance is needed to identify infusion site.

Medication	Dose	Directions	Quantity/Refills
❑ Cimzia® (certolizumab)	❑ 200mg/mL solution in a single-dose prefilled syringe (PFS) ❑ 200mg/mL solution in a single-dose PFS Starter Kit ❑ 200mg/mL lyophilized powder in a single-dose vial for reconstitution	❑ Inject 400mg subcutaneously every other week. ❑ Inject 400mg subcutaneously at weeks 0, 2 and 4, followed by 200mg every other week. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Cosentyx® (secukinumab)	❑ 150mg/mL solution in a single-use Sensoready pen ❑ 150mg/mL solution in a single-use PFS ❑ 150mg lyophilized powder in a single-use vial for reconstitution (for healthcare professional use only)	❑ Inject 300mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by 300mg every 4 weeks. Each 300mg dose is given as 2 subcutaneous injections of 150mg. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Enbrel® (etanercept)	❑ 25mg PFS ❑ 50mg PFS ❑ 50mg SureClick™ ❑ 25mg multiuse vial ❑ 50mg Mini Cartridge	❑ Inject 50mg subcutaneously once a week. ❑ Inject 50mg subcutaneously twice a week x 3 months, then 50mg a week once a week. ❑ Inject _____mg subcutaneously _____per week	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Humira® (adalimumab)	**Initial dose:** ❑ 40mg/0.4mL citrate-free pens starter package ❑ 40mg/0.8mL pens starter package ❑ 80mg/0.8mL and 40mg/0.4mL citrate-free pens starter package **Maintenance dose:** ❑ 40mg/0.4mL citrate-free pen ❑ 40mg/0.4mL citrate-free prefilled syringe ❑ 40mg/0.8mL pen ❑ 40mg/0.8mL prefilled syringe	❑ If new, inject 80mg initial dose, followed by 40mg every other week starting one week after initial dose. ❑ If continuing therapy, inject 40mg subcutaneously every other week. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Ilumya™ (tildrakizumab-asmn)	❑ 100mg/mL in a single-dose prefilled syringe	❑ Inject 100mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter. ❑ Inject 100mg subcutaneously every 12 weeks. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. 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 (sign below) (Physician attests this is his/her legal signature. NO STAMPS) PHYSICIAN SIGNATURE REQUIRED

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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