

## PSORIASIS SPECIALTY CARE PROGRAM

### 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: \_\_\_\_\_ Serious or active infection present?  Yes  No  
 ICD-10: \_\_\_\_\_ Does patient have latex allergy?  Yes  No  
 Other: \_\_\_\_\_ Hep B ruled out or treatment started?  Yes  No  
 TB Test:  Positive  Negative Date: \_\_\_\_\_ History of malignancy?  Yes  No  
 Assessment:  Moderate  Mod to Severe  Severe History of MS or other demyelinating disease?  Yes  No  
 \_\_\_\_\_ % BSA affected New onset CHF or worsening CHF?  Yes  No  
 Hands  Scalp  Feet  Groin  Nails  
 Contraindications for oral agent(s) or phototherapy?  No  Yes \_\_\_\_\_

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Topicals	_____
<input type="checkbox"/> Methotrexate	_____
<input type="checkbox"/> Oral Meds	_____
<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> PUVA <input type="checkbox"/> UVB	_____
<input type="checkbox"/> Others	_____

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

### 4 PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> COSENTYX™	<input type="checkbox"/> 150mg/ml Sensoready® Pen <input type="checkbox"/> 150mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
		<input type="checkbox"/> Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
		<input type="checkbox"/> Maintenance Dose: Inject 300mg SC every four weeks	2	
		<input type="checkbox"/> Maintenance Dose: Inject 150mg SC every four weeks	1	
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> Other: _____	<input type="checkbox"/> Induction Dose: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
		<input type="checkbox"/> Maintenance: Inject 50mg SC once a week	4	
		<input type="checkbox"/> Other: _____		
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Psoriasis Starter Package <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> Hidradenitis Suppurativa Starter Package <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> Patient has signed HUMIRA Complete form	<input type="checkbox"/> Induction Dose: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	4	0
		<input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week	2	
		<input type="checkbox"/> Induction Dose: 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"/> Maintenance Dose: Inject 40mg SC every week	4	
<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> Starter Pack (Titration) <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Starter Pack: 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"/> Maintenance Dose: Take one 30mg tablet by mouth twice daily	60	
<input type="checkbox"/> SIMPONI® (for PsA)	<input type="checkbox"/> 50mg/0.5ml Smartject Injector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs) <input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs) <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"/> Induction Dose: Inject the contents of 1 prefilled syringe SC on day 1	1	0
		<input type="checkbox"/> Maintenance Dose: Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1	
<input type="checkbox"/> TALTZ®	<input type="checkbox"/> 80mg/ml Prefilled Autoinjector <input type="checkbox"/> 80mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 160mg SC at week 0, then inject 80mg week 2 then inject 80mg SC every 2 weeks (weeks 4-10) then inject 80mg SC at week 12	3	0
			2	1
		<input type="checkbox"/> Maintenance Dose: Inject 80mg SC every 4 weeks	1	0
<input type="checkbox"/>				

**5 INJECTION TRAINING:**  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**6 PRODUCT DELIVERY:**  Patient's Home  Physician's Office  Pharmacy to Coordinate

**7 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**8 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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