PSORIASIS AND PSORIATIC ARTHRITIS SPECIALTY CARE PROGRAM

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	Alt. Phone:		Phone:				
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DOB:	Gender: OM OF Caregiver:	•	lax I.D.:				
-leight: V	Gender: O M O F Caregiver: Neight: Allergies:		Office Contact:		Phone:		
Date of Diagnosis: ICD-10: TB Test:	Other: Negative Date: AST: Date: lerate I Mod to Severe I Severe	Patient also takin Serious or active Hep B ruled out of Does patient hav Does patient hav If yes, please ind If Prior Authorizat formulary alternat based upon the patient Healthcare Provider Concerner O Physicia	an's Office O Pharmacist to Provide Training	Yes No Yes No Yes No prescriber O Patient Train	Others ed in MD Office O Manu ordinate	ufacturer Nurs	
Patient Name:	NINFORMATION: (Please b		se both induction and Patient	d maintena 's Date of E	nce dose where		-
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Patient Name:	·	e sure to choos	se both induction and Patient	d maintena 's Date of E tion	nce dose where Birth:	QTY	-
Patient Name: Medication	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 15mg 15mg 25mg 25mg 25mg	e sure to choos	se both induction and Patient' Direct mg SC once weekly est dose of 2.5 to 5 mg is rect	d maintena 's Date of E tion ommended in f impairment*	nce dose where Birth: patients with risk s 0, 1 and 2		-
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Patient Name: Medication □ RASUVO [®] □ SILIQ [™] □ SILIQ [™] □ SIMPONI [®]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 15mg 17.5mg 20mg 22.5mg 25mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector	e sure to choose An initial te factors for h Induction Maintena Inject 50r Induction	se both induction and Patient' Direct mg SC once weekly est dose of 2.5 to 5 mg is reco nematologic toxicity or renal in Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan mg SC once a month Dose: Inject 150mg (two 75mg	d maintena 's Date of B tion ommended in p impairment* neously at Week utaneously even	nce dose where Birth: patients with risk s 0, 1 and 2 y 2 weeks at weeks 0 and 4	QTY	-
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Patient Name: Medication □ RASUVO [®] □ SILIQ [™] □ SIMPONI [®]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg □ 10mg □ 12.5mg □ 15mg 17.5mg □ 20mg □ 22.5mg □ 25mg 27.5 mg □ 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe	See sure to choose An initial te factors for h An initial te factors for h Maintena Induction Maintena Induction Maintena Healthcare provider cert Adult dos then ever Adult Dos then ever Psoriatic Ar	se both induction and Patient' Direc: mg SC once weekly set dose of 2.5 to 5 mg is rect hematologic toxicity or renal in Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan nace Inject 150mg (two 75mg (two 75mg (two 75mg (two 75mg (d maintena 's Date of E tion ommended in p impairment* neously at Week utaneously every g injections) SC actions) SC every and is eligible for initially and at 4	nce dose where Birth: patients with risk s 0, 1 and 2 y 2 weeks at weeks 0 and 4 12 weeks thereafter self-injection 4 weeks, 4 weeks,	QTY	Refills
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Patient Name: Medication □ RASUVO [®] □ SILIQ [™] □ SIMPONI [®] (for PsA) □ SKYRIZI [™]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 17.5mg 20mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe Yes or No: SKYRIZI SELF-INJECTION:	De sure to choose : Inject	se both induction and Patient' Direc: mg SC once weekly est dose of 2.5 to 5 mg is rec rematologic toxicity or renal in Dose: Inject 210mg subcutan ince Dose: Inject 210mg subcutan ince Dose: Inject 210mg subcutan ing SC once a month Dose: Inject 150mg (two 75mg ince: Inject 150mg (two 75mg ince: Inject 150mg (two 75mg ing (≤100 kg): Inject 45 mg SC y 12 weeks thereafter sing (<100 kg): Inject 45 mg SC y 12 weeks thereafter thritis: mg SC initiation and at 4 weeks thritis (PsA): Dose: Inject 160 mg SC (two 8 ince: Inject 160 mg SC (two 8	d maintena 's Date of E tion ommended in p impairment* neously at Week utaneously every and is eligible for initially and at 4 c initially and at 4 c initia	nce dose where Birth: patients with risk s 0, 1 and 2 y 2 weeks at weeks 0 and 4 12 weeks thereafter self-injection 4 weeks, 4 weeks, 4 weeks, 4 weeks, 5 weeks thereafter at week 0 evere Plaque Psoriasis reeks 0,	QTY	Refill
Patient Name: Medication □ RASUVO [®] □ SILIQ [™] □ SILIQ [™] □ SIMPONI [®] □ SKYRIZI [™] □ STELARA [®]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 15mg 17.5mg 20mg 22.5mg 25mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe Yes or No: SKYRIZI SELF-INJECTION: 45mg/0.5 mL Single-Dose Prefilled Syringe 45mg/0.5 mL Solution in a Single-Dose 80mg/ml Single-Dose Prefilled Autoinje	See sure to choose An initial te factors for h Induction Maintenar Inject 50r Maintenar Healthcare provider cert Adult dos then ever Plaque Psoo Induction Maintenar Healthcare normatic Ar Induction Maintenar Adult dos then ever Psoriatic Ar Induction Maintenar Maintenar Adult dos then ever Psoriatic Ar Induction Maintenar Maintenar Contact Ar Induction Maintenar	se both induction and Patient' Direct mg SC once weekly est dose of 2.5 to 5 mg is recon- nematologic toxicity or renal in Dose: Inject 210mg subcutan Dose: Inject 210mg subcutan Dose: Inject 210mg subcutan Dose: Inject 210mg subcutan Dose: Inject 150mg (two 75mg Dose: Inject 150mg (two 75mg Dose: Inject 150mg (two 75mg Dose: Inject 150mg (two 75mg Inject 100 kg): Inject 45 mg SC y 12 weeks thereafter Thritis: mg SC initiation and at 4 weeks thritis (PsA): Dose: Inject 160 mg SC (two 8 Inject 160mg SC (two 8 Inject 160mg SC (two 80mg It 80mg SC at week 2 -10: Inject 80mg SC at week 4 through week 10	d maintena 's Date of E tion ommended in p impairment* neously at Week- utaneously even g injections) SC ections) SC every and is eligible for initially and at 4 c initially and at 4 c initially and at 4 c s, then every 12 30 mg injections veeks thereafter Moderate-to-So g injections) at w	nce dose where Birth:	QTY QTY Otherwise QTY Otherwise QTY Otherwise Qtexture Qt	Refill 0
Patient Name: Medication □ RASUVO® □ SILIQ [™] □ SKYRIZI [™] □ STELARA® □ TALTZ [®]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 15mg 17.5mg 20mg 22.5mg 25mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe Yes or No: SKYRIZI SELF-INJECTION: 45mg/0.5 mL Single-Dose Prefilled Syringe 45mg/0.5 mL Solution in a Single-Dose 80mg/ml Single-Dose Prefilled Autoinje 80mg/ml Single-Dose Prefilled Syringe	See sure to choose An initial te factors for h Induction Maintena Inject 50r Maintena Inject 50r Maintena Healthcare provider cert Adult dos then ever Plaque Psoriatic Ar Induction Maintena Adult cos then ever Psoriatic Ar Induction Maintena Adult cos then ever Psoriatic Ar Induction Maintena Maintena then ever Psoriatic Ar Induction Maintena Mainten	Se both induction and Patient' Direct mg SC once weekly est dose of 2.5 to 5 mg is recon- mematologic toxicity or renal in Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan nace Inject 150mg (two 75mg nce: Inject 150mg (two 75mg nce: Inject 150mg (two 75mg inje- tifies that patient has been trained riasis: ing (≤100 kg): Inject 45 mg SC y 12 weeks thereafter sing (>100 kg): Inject 90 mg SC y 12 weeks thereafter thritis: (PsA): Dose: Inject 160 mg SC (two 8 nce: Inject 160 mg SC (two 8 nce: Inject 160 mg SC (two 80mg it 80mg SC at week 2 -10: Inject 80mg SC at week 4 through week 10 and onwards: Inject 80mg SC	d maintena 's Date of E tion ommended in p impairment* neously at Week utaneously every g injections) SC ections) SC every and is eligible for initially and at 4 c initially and	nce dose where Birth:	QTY QTY Otherwise QTY Otherwise QTY Otherwise Qtexture Qt	0 0 0
Patient Name: Medication RASUVO [®] SILIQ [™] SILIQ [™] SIMPONI [®] SKYRIZI [™] SKYRIZI [™]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 17.5mg 20mg 22.5mg 25mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe Yes or No: SKYRIZI SELF-INJECTION: 45mg/0.5 mL Single-Dose Prefilled Syringe 45mg/0.5 mL Solution in a Single-Dose 80mg/ml Single-Dose Prefilled Autoinje 80mg/ml Single-Dose Prefilled Syringe	De sure to choose De sure to choose * An initial te factors for h Induction Maintenar Healthcare provider cert Plaque Psoo Adult dos then ever Psoriatic Ar Inject 45 r Psoriatic Ar Induction Adult dos then ever Psoriatic Ar Induction Maintenar etor Psoriatic Ar Induction Maintenar etor Psoriatic Ar Induction Maintenar etor Weeks 0- there inject etor Weeks 12 i Unduction	Se both induction and Patient' Direc: mg SC once weekly est dose of 2.5 to 5 mg is rece- hematologic toxicity or renal in Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan mg SC once a month Dose: Inject 150mg (two 75mg nce: Inject 150mg (two 75mg inject <i>tifies that patient has been trained</i> riasis: ing (≤100 kg): Inject 45 mg SC y 12 weeks thereafter sing (>100 kg): Inject 90 mg SC y 12 weeks thereafter thritis: mg SC initiation and at 4 weeks thritis (PsA): Dose: Inject 160 mg SC (two 8 nce: Inject 80 mg SC every 4 w riasis or PSA with Coexistent : : Inject 160mg SC (two 80mg it 80mg SC at week 2 : : Inject 80mg SC at week 4 through week 10 and onwards: Inject 80mg SC n Dose: Inject 100mg/ml SC	d maintena 's Date of E tion ommended in p impairment* neously at Week utaneously even g injections) SC ections) SC every and is eligible for initially and at 4 c initially and	nce dose where Birth:	QTY QTY Otherwise QTY Otherwise QTY Otherwise Qtexture Qt	0 0
Patient Name: Medication □ RASUVO® □ SILIQ [™] □ SILIQ [™] □ SIMPONI® □ SKYRIZI [™] □ SKYRIZI [™] □ STELARA® □ TALTZ® □ TREMFYA [™]	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 15mg 17.5mg 20mg 22.5mg 25mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe Yes or No: SKYRIZI SELF-INJECTION: 45mg/0.5 mL Single-Dose Prefilled Syringe 45mg/0.5 mL Solution in a Single-Dose 80mg/ml Single-Dose Prefilled Autoinje 80mg/ml Single-Dose Prefilled Syringe 100mg/ml Prefilled Syringe 100mg/ml Prefilled Syringe	De sure to choose De sure to choose *An initial te factors for h Induction Maintena Inject 50r Haque Psor Adult dos then ever Plaque Psor Adult Dos then ever Psoriatic Ar Inject 45 r Psoriatic Ar Induction Parame Psoriatic Ar Induction Waintena etor Psoriatic Ar Induction Waintena etor Weeks 0- there inject there are inject there inject Induction Maintenar Induction Weeks 4- thereafter Weeks 4- thereafter Weeks 4- thereafter Induction d Injector Maintenar	se both induction and Patient' Direc: mg SC once weekly est dose of 2.5 to 5 mg is rec nematologic toxicity or renal in Dose: Inject 210mg subcutan ince Dose: Inject 210mg subcutan ince Dose: Inject 210mg subcutan ing SC once a month Dose: Inject 150mg (two 75mg ing inject 150mg (two 75mg ing inject 150mg (two 75mg ing islame) (two 75mg inject iffies that patient has been trained riasis: ing (≤100 kg): Inject 45 mg SC y 12 weeks thereafter sing (>100 kg): Inject 45 mg SC y 12 weeks thereafter thritis: mg SC initiation and at 4 weeks thritis (PsA): Dose: Inject 160 mg SC (two 8 mce: Inject 160 mg SC (two 8 mce: Inject 160 mg SC (two 8 mce: Inject 160 mg SC at week 4 through week 10 and onwards: Inject 80mg SC ance: Inject 100mg/ml SC ance: Inject 100mg/ml SC events 100mg/ml SC ev	d maintena 's Date of E tion ommended in p impairment* neously at Week utaneously every g injections) SC ections) SC every and is eligible for initially and at 4 c initially an	nce dose where Birth:	QTY	0 0 0
Patient Name: Medication RASUVO® SILIQ [™] SILIQ [™] SIMPONI® SKYRIZI [™] SKYRIZI [™] TALTZ®	Dosage & Strength Single-dose auto-injector prefilled syringe: 7.5mg 10mg 12.5mg 15mg 17.5mg 20mg 22.5mg 25mg 27.5 mg 30mg 210mg/1.5ml Prefilled Syringe 50mg/0.5ml Smartject Injector 50mg/0.5ml Prefilled Syringe 75mg/0.83ml Prefilled Syringe Yes or No: SKYRIZI SELF-INJECTION: 45mg/0.5 mL Single-Dose Prefilled Syringe 45mg/0.5 mL Solution in a Single-Dose 80mg/ml Single-Dose Prefilled Autoinje 80mg/ml Single-Dose Prefilled Syringe 100mg/ml Prefilled Syringe 100mg/ml Prefilled Syringe 100mg/ml Prefilled Syringe Smg Tablet	De sure to choose : Inject	Se both induction and Patient' Direc: mg SC once weekly est dose of 2.5 to 5 mg is rece- hematologic toxicity or renal in Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan nace Dose: Inject 210mg subcutan mg SC once a month Dose: Inject 150mg (two 75mg nce: Inject 150mg (two 75mg inject <i>tifies that patient has been trained</i> riasis: ing (≤100 kg): Inject 45 mg SC y 12 weeks thereafter sing (>100 kg): Inject 90 mg SC y 12 weeks thereafter thritis: mg SC initiation and at 4 weeks thritis (PsA): Dose: Inject 160 mg SC (two 8 nce: Inject 80 mg SC every 4 w riasis or PSA with Coexistent : : Inject 160mg SC (two 80mg it 80mg SC at week 2 : : Inject 80mg SC at week 4 through week 10 and onwards: Inject 80mg SC n Dose: Inject 100mg/ml SC	d maintena 's Date of E tion ommended in p impairment* neously at Week utaneously every g injections) SC actions) SC every and is eligible for initially and at 4 s, then every 12 30 mg injections veeks thereafter Moderate-to-Sc g injections) at w and every 2 we at week 12 and at weeks 0 and very 8 weeks the combination with	nce dose where Birth:	QTY	0 0 0

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. If Prescribing SILIQ[™]: I certify that I made the prescribing decisions indicated above based on my own independent medical judgment regarding what is in the best interest of the patient and that have reviewed the current SILIQ Prescribing Information. By signing above, I confirm that: (1) I are certified as a healthcare provider under the SILIQ REMS Program, (2) I have counseled the patient on the risks of suicidal ideation and behavior that may occur with SILIQ, (3) the patient has signed the SILIQ REMS Patient-Prescriber Agreement, (4) I have given the patient the SILIQ REMS Program, REMS patient wallet card, and (5) I have enrolled the patient in the SILIQ REMS Program. I authorize SILIQ Solutions to act on my behalf to transmit this prescription to the appropriate qualified pharmacy designated above by the patient or the patient's plan.

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