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: _____
ICD-10: _____ Other: _____
TB Test: ❑ Positive ❑ Negative Date: _____
LFT: ALT: _____ AST: _____ Date: _____
Assessment: ❑ Moderate ❑ Mod to Severe ❑ Severe
_____% BSA affected
❑ Scalp ❑ Face ❑ Chest ❑ Arms ❑ Hands ❑ Nails
❑ Back ❑ Groin ❑ Buttocks ❑ Legs ❑ Other: _____

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:

❑ Topicals _____
❑ Methotrexate _____
❑ Oral Meds _____
❑ Biologics _____
❑ UVA ❑ UVB _____
❑ Others _____

4 INJECTION TRAINING:

❍ To be Administered by a Healthcare Provider ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY:

❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

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

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

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ RASUVO®	❑ _____	❑ _____		
❑ SILIQ™	❑ 210mg/1.5ml Prefilled Syringe	❑ **Induction Dose:** Inject 210mg subcutaneously at Weeks 0, 1 and 2 ❑ **Maintenance Dose:** Inject 210mg subcutaneously every 2 weeks	❑ 1 Months ❑ 2 Months ❑ 3 Months	
❑ SIMPONI® (for PsA)	❑ 50mg/0.5ml Smartject Injector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month	1	
❑ SKYRIZI™	❑ 75mg/0.83ml Prefilled Syringe	❑ **Induction Dose:** Inject 150mg (two 75mg injections) SC at weeks 0 and 4	4	0
		❑ **Maintenance:** Inject 150mg (two 75mg injections) SC every 12 weeks thereafter	2	
	❑ Yes or ❑ No: ***SKYRIZI SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ STELARA®	❑ 45mg/ml Single-Dose Vial	❑ **Induction Dose:** To achieve pediatric dose:		
		❑ < 60kg: Inject 0.75mg/kg		0
		❑ 60kg - 100kg: Inject 45mg SC	1	0
		❑ > 100kg: Inject 90mg SC	1	0
	❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs)	❑ Inject the contents of 1 prefilled syringe SC on day 1		
	❑ 90mg/1ml Prefilled Syringe (for > 220 lbs)	❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter	1	
	❑ Yes or ❑ No: ***STELARA SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ TALTZ®	❑ 80mg/ml Single-Dose Prefilled Autoinjector ❑ 80mg/ml Single-Dose Prefilled Syringe	❑ **Weeks 0-2:** Inject 160mg SC (two 80mg injections) at weeks 0, then inject 80mg SC at week 2	3	0
		❑ **Weeks 4-10:** Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	2	1
		❑ **Week 12 and onwards:** Inject 80mg SC at week 12 and every 4 weeks thereafter	1	
❑ TREMFYA™	❑ 100mg/ml Prefilled Syringe ❑ 100mg/ml One- Press Patient Controlled Injector	❑ **Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4	2	0
		❑ **Maintenance:** Inject 100mg/ml SC every 8 weeks thereafter	1	
❑ XELJANZ®	❑ 5mg Tablet	❑ Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
❑ XELJANZ® XR	❑ 11mg Tablet	❑ Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	
❑ _____	_____	_____		

Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia™ and Otezla® are listed alphabetically on respective enrollment forms.

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 I have reviewed the current SILIQ Prescribing Information. By signing above, I confirm that: (1) I am 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 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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