

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
 _____% BSA affected disease? Yes No
 Hands Scalp Feet Groin Nails New onset CHF or worsening CHF? Yes No
 Contraindications for oral agent(s) or
 phototherapy? No Yes _____

Prior Failed Treatments: **Indicate Drug Name and Length of Treatment:**

Topicals _____
 Methotrexate _____
 Oral Meds _____
 Biologics _____
 PUVA UVB _____
 Others _____

If Prior Authorization is Denied:
 Automatically Draft Appeal for Review
 Send Formulary Preferred 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"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector	<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"/> 50mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 50mg SC once a week	4	
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Psoriasis Starter Package	<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"/> 40mg/0.8ml Pen	<input type="checkbox"/> Maintenance: Inject 40mg SC every other week	2	
	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Hidradenitis Suppurativa Starter Package	<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"/> OTEZLA®	<input type="checkbox"/> 40mg/0.8ml Pen	<input type="checkbox"/> Maintenance: Inject 40mg SC every week	4	
	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<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"/> Patient has signed HUMIRA Complete form	<input type="checkbox"/> Maintenance: Take one 30mg tablet by mouth twice daily	60	
<input type="checkbox"/> SIMPONI® (for PsA)	<input type="checkbox"/> Starter Pack (Titration)	<input type="checkbox"/> Induction Dose: Inject 50mg SC once a month	1	
	<input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Maintenance: Inject 50mg SC once a month	1	0
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 50mg/0.5ml Smartject Injector	<input type="checkbox"/> Induction Dose: Inject the contents of 1 prefilled syringe SC on day 1	1	0
	<input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1	
	<input type="checkbox"/> 45mg/0.5ml 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"/> 90mg/1ml Prefilled Syringe (for > 220 lbs)				

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.