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PSORIASIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient:_____ Caregiver: _____

DOB:_____ ☐ Male ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Height_____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address:_____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies:_____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

TB/PPD Test Given? ☐ Yes ☐ No Date of negative TB test: _____ Hep B ruled out? ☐ Yes ☐ No
If no, treatment started? ☐ Yes ☐ No

Does patient have a latex allergy? ☐ Yes ☐ No

_____% BSA affected by psoriasis

Do the affected areas include the palms, soles, head, neck, or genitalia? ☐ Yes ☐ No

Additional justification for drug:_____

_____

PRIOR (FAILED) THERAPY:
☐ Enbrel ☐ Humira ☐ Simponi ☐ Stelara
☐ Methotrexate ☐ PUVA ☐ UVB

Topicals (please list): _____

Other (please list): _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Cimzia® (certolizumab) Only for psoriatic arthritis ☐ Enroll in Cimzia® Connect	Starter Dose: ☐ Starter Kit (200mg Prefilled Syringes) ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200mg/mL PFS ☐ 3 Kits = 3 cartons of 2 x 200mg Vials	0
	Maintenance Dose: ☐ 200mg/mL Prefilled Syringe ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200mg/mL PFS ☐ 1 Carton = 2 x 200mg Vials	_____
Cosentyx® (secukinumab) ☐ Enroll in Cosentyx® Connect	Starter Dose: ☐ 5 x 150mg/mL ☐ 10 x 150mg/mL	☐ 150 mg SQ at week 0, 1, 2, 3 and 4 ☐ 300 mg SQ at week 0, 1, 2, 3 and 4	_____Pen OR _____ PFS	0
	Maintenance Dose: ☐ 1 x 150mg/mL ☐ 2 x 150mg/mL	☐ 150 mg SQ every 4 weeks ☐ 300 mg SQ every 4 weeks	_____Pen OR _____ PFS	_____
Dupixent® (dupilumab) ☐ Enroll in Dupixent® MyWay	Starter Dose: ☐ 2 x 300mg/2 mL	☐ 600 mg SQ on day 1	1 x PFS	0
	Maintenance Dose: ☐ 1 x 300mg/2 mL	☐ 300 mg SQ every other week	_____ PFS	_____
Enbrel® (etanercept) ☐ Enroll in Enbrel® Support ☐ Enroll in Enbrel® Nurse Partner	Psoriasis Starter Dose: ☐ 8 x 50mg/mL x 3 months	☐ 50 mg SQ TWICE a week (72-96 hours apart) x 3 months	☐ 8 Sureclick Autoinjectors, OR ☐ 8 PFS	2
			☐ 8 Mini Cartridge Solution for Injection	2
	Maintenance Dose: ☐ 4 x 50mg/mL ☐ 8 x 25mg/mL	☐ 50 mg SQ every week ☐ 25 mg SQ TWICE a week	☐ 4 Sureclick Autoinjectors, OR ☐ 4 PFS	_____
			☐ 4 Mini Cartridge Solution for Injection ☐ 8 x25mg PFS OR 8 x25mg Vials	_____
Humira® (adalimumab) ☐ Enroll in Humira® Complete	Psoriasis Starter Dose: ☐ 4 x 40mg/0.8mL Pen	☐ 80 mg SQ day 1, then 40 mg every other week, starting 1 week after initial dose	☐ 4 Pens OR 4 PFS	0
	Hidradentitis Suppurativa Starter: ☐ 6 x 40mg/0.8mL	☐ 160 mg SQ day 1, then 80 mg on day 15, then 40 mg weekly starting on day 29	☐ 6 Pens OR 6 PFS	0
	Maintenance Dose: ☐ 2 x 40mg/0.8mL ☐ 4 x 40mg/0.8mL	☐ 40 mg SQ every two weeks ☐ 40 mg SQ every week	☐ 2 Pens OR 2 PFS ☐ 4 Pens OR 4 PFS	_____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Otezla® (apremilast)) ☐ Enroll in Otezla® Support ☐ Enroll in Otezla® Starter Kit Received	Starter Dose: ☐ 28 days titrating dose Other _____	per manufacturer titrating dosing schedule _____	1 pack	0
	Maintenance Dose: ☐ 60 x 30mg tablets	☐ 30 mg po twice daily	_____ pack of 60 tabs)	_____
Remicade® (infliximab) ☐ Inflectra ☐ Renflexis ☐ Enroll in CarePath®	Starter Dose: ☐ 5mg/kg	_____ mg IV infusion at weeks 0, 2, and 6	_____ Vial(s)	0
	Maintenance Dose: ☐ 100mg Lyophilized Vial(s)	_____ mg IV every 8 weeks	_____ Vial(s)	_____
Simponi® (golimumab) Only for psoriatic arthritis ☐ Enroll in CarePath®	☐ 1 x 50mg/0.5mL	☐ 50 mg SQ every month	_____SmartJect Autoinjector **OR** _____PFS	_____
Stelara™ (ustekinumab) ☐ Enroll in CarePath®	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	Initiation Dose: ☐ Inject the contents of 1 prefilled syringe Sub-Q initially Day 1	☐ 1	0
		Maintenance Dose: ☐ Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	☐ 1	_____
Taltz® (ixekizumab) ☐ Enroll in Taltz® Savings Program	Starter Dose: ☐ 2 x 80mg/mL ☐ 6 x 80mg/mL	☐ 160 mg SQ at week 0 ☐ 80 mg SQ at weeks 2, 4, 6, 8, 10, 12	☐ 2 PFS **OR** ☐ 2 AutoInject ☐ 6 PFS **OR** ☐ 6 AutoInject	0 0
	Maintenance Dose: ☐ 1 x 80mg	☐ 80 mg SQ every 4 weeks	_____ PFS **OR** _____ AutoInject	
Tremfya® (guselkumab) ☐ Jenssen CarePath®	Starter Dose: ☐ 2 x 100mg/mL	☐ 100 mg SQ at weeks 0 and 4	2 PFS	_____
	Maintenance Dose: ☐ 1 x 100mg	☐ 100 mg SQ at week 8	_____PFS	
Other				_____

INJECTION TRAINING: ☐ **OFFICE TO COORDINATE** ☐ **USSC TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____

Fax #: _____Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

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☐ I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____Prescriber's Signature: _____Date: _____

☐ Use substitution ☐ Dispense as Written