



**Patient Information**

Patient name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Cell \_\_\_\_\_  
 DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Drug allergies \_\_\_\_\_  Male  Female

**Prescriber Information**

Prescriber name \_\_\_\_\_ Lic# \_\_\_\_\_  
 DEA# \_\_\_\_\_ Tax ID \_\_\_\_\_  
 Practice name \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Insurance, Medicare or Medicaid Information**

Primary Insurance \_\_\_\_\_ Secondary Insurance (*If applicable*) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
 Insurance phone \_\_\_\_\_ Insurance phone \_\_\_\_\_  
 Prescription Drug Coverage: Company \_\_\_\_\_ Phone \_\_\_\_\_  
 RXGRP# \_\_\_\_\_ RXBIN# \_\_\_\_\_ PCN/ID# (if avail.) \_\_\_\_\_  
 COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

**Clinical Information**

Diagnosis:  696.1 Psoriasis  696.0 Psoriatic Arthritis  Other \_\_\_\_\_ Loc. of psoriasis:  Hands  Feet  Scalp  Groin  Nails  Other: \_\_\_\_\_  
 Severity of psoriasis:  Mild (up to 3% BSA)  Moderate (3-10% BSA)  Severe (>10% BSA), BSA \_\_\_\_\_% Previously treated for this condition?  Yes  No  
 Medication/Therapy failed & length:  Topical \_\_\_\_\_  Light therapy \_\_\_\_\_  Methotrexate \_\_\_\_\_  Soriatane \_\_\_\_\_  Cyclosporine \_\_\_\_\_  Others \_\_\_\_\_  
 Is patient currently on therapy?  Yes  No Type/medication(s): \_\_\_\_\_ Patient tested for TB/PPD?  Yes  No Results \_\_\_\_\_  
 Will patient stop the above medication(s) before starting the new medication?  Yes  No If yes, how long should patient wait before starting new medication? \_\_\_\_\_  
 Other medications patient is currently taking including OTC medications w/ dosage & directions (or fax medication profile): \_\_\_\_\_

| Drug name  | Prescription Orders<br>(PLEASE CHECK ONE OR MORE)   | Quantity   | Refills                                |
|--|---|--|--|
| Enbrel® 50mg/ml<br><input type="radio"/> SureClick Auto-Injector<br><input type="radio"/> PFS (prefilled syringes) | <input type="radio"/> <b>Induction:</b> inject 50mg SC twice weekly for three months then maintenance dose<br><input type="radio"/> <b>Maintenance:</b> 50mg SC weekly<br><input type="radio"/> <b>Other:</b> _____   | 28 day supply  | Refills                                |
| Enbrel® 25mg/0.5ml<br><input type="radio"/> Pre-filled syringe<br><input type="radio"/> Vial kit                   | <input type="radio"/> 25mg SC twice weekly<br><input type="radio"/> <b>Other:</b> _____   | 28 day supply  | Refills                                |
| Humira®<br><input type="radio"/> Pen<br><input type="radio"/> Syringe  | <input type="radio"/> <b>Induction:</b> Inject 80mg (2 pens) SC on Day 1, then 40 mg (1 Pen) on Day 8, followed by maintenance dose<br><input type="radio"/> <b>Maintenance:</b> 40mg SC every other week [OR] <input type="radio"/> <b>Other:</b> _____  | 28 day supply  | Refills                                |
| <input type="radio"/> Stelara® 45mg Pre-filled syringe<br><input type="radio"/> Stelara® 90mg Pre-filled syringe   | <input type="radio"/> <b>≤ 100kg Body Weight:</b> Inject 45mg SC on Day 1, again after 4 weeks, then every 12 weeks thereafter.<br><input type="radio"/> <b>&gt; 100kg Body Weight:</b> Inject 90mg SQ on Day 1, again after 4 weeks, then every 12 weeks thereafter<br>Either dose is to be administered by a healthcare provider. | 28 Day supply initially, to be refilled after 4 weeks, then every 12 weeks thereafter. | Approved for how many months?<br>_____ |
| <input type="radio"/> Remicade®<br>100mg vial  | Directions  | Qty  | Refills                                |
| Other Medications:   | Directions  | Qty  | Refills                                |

**Deliver to:**  Patient's home  MD's office  1<sup>st</sup> dose to MD's office, remaining refills to patient home **Injection training needed?**  Yes  No

*We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.*

\_\_\_\_\_  
**Prescriber name or signature** **Office Contact Name (Nurse, MA, Other)** **Preferred phone number & extension** **Date**