

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: _____ Patient also taking Methotrexate? Yes No
 ICD-10: _____ Other: _____ Serious or active infection present? Yes No
 TB Test: Positive Negative Date: _____ Hep B ruled out or treatment started? Yes No
 LFT: ALT: _____ AST: _____ Date: _____ Does patient have latex allergy? Yes No
 Assessment: Moderate Mod to Severe Severe
 _____% BSA affected
 Scalp Face Chest Arms Hands Nails
 Back Groin Buttocks Legs Other: _____

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

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.