elixir
SPECIALTY PHARMACY

Psoriasis Enrollment Form
Fax: 877-309-0687 Phone: 877-437-9012

Patient Information

Patient Name: _____ Date of Birth: _____
Sex: _____Home Phone: _____ E-mail: _____
Work phone: _____ Cell Phone: _____
Address: _____
City: _____ State: ____ Zip: _____

Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Relationship to Patient: _____
Policy holder Employer: _____
ID# _____ Group# _____ RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
Physician Name: _____
Physician's Specialty: _____
Address: _____
City: _____State: ____ Zip: _____
Phone #: _____Fax#: _____
DEA: _____NPI# _____
License#: _____Medicaid UPIN#: _____
Date Shipment Needed: _____
Ship to: ☐Patient ☐Prescriber ☐Other _____
Shipment Address: _____
City: _____ State: ____ Zip: _____
Attn: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information

Diagnosis: ☐ L40. ____ Psoriasis ☐ L40.54 Juvenile Psoriatic Arthritis ☐ L40.59 Psoriatic Arthritis ☐ Other: _____
Date of Diagnosis or Years with Disease: _____

Allergies (☐ NKDA): _____
Patient Weight: _____ Patient Height: _____
BSA (Body Surface Area) affected by Psoriasis: _____%
Has Hepatitis B been ruled out? ☐ YES ☐ NO
NEGATIVE tuberculin skin test? ☐ YES ☐ NO
BSA (Body Surface Area) affected by Psoriasis: _____%
Prior Failed Medications and date_____

Expected First Dose Date: _____
Injection Instruction needed: ☐YES ☐NO ☐ In-office administration or training.

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☐ **NEW** TO THERAPY ☐ **CURRENT** TO THERAPY

☐**Cimzia®** (certolizumab pegol) ☐ 200mg Prefilled Syringes ☐ 200mg Vials ☐ 200mg Starter Kit
- ☐ Initial: Inject 400 mg SC at weeks 0, 2 and 4, followed by proper maintenance dose
- ☐ Maintenance: Inject 200 mg SC every other week (Wt ≤90 kg)
- ☐ Inject 400 mg SC every other week (Wt >90kg)
- ☐ Other: _____

☐ **Cosentyx®** (secukinumab) ☐ 150mg Pen Auto injector ☐ 75mg Prefilled Syringe ☐ 150mg Prefilled Syringe
- ☐Initial: Inject 150mg SC at weeks 0,1,2,3,4, then 150mg SC every 4 weeks OR ☐ Initial: Inject 300mg SC at weeks 0,1,2,3,4, then 300mg SC every 4 weeks
- ☐Maintenance: Inject 150mg SC every 4 weeks OR ☐ Maintenance: Inject 300mg SC every 4 weeks
- ☐Initial (for pediatric <50kg): Inject 75mg SC at weeks 0,1,2,3,4, then 75mg SC every 4 weeks
- ☐Maintenance (for pediatric <50kg): Inject 75mg SC every 4 weeks
- ☐ Other: _____

☐ **Enbrel®** (etanercept) ☐50mg SureClick ☐50mg Mini AutoTouch ☐50mg PF Syringe ☐25mg Prefilled Syringe ☐25mg Vial
- ☐ Initial: Inject 50 mg SC twice per week (3-4 days apart) x 3 months
- ☐ Maintenance: Inject 50mg SC once per week
- ☐ Maintenance: Inject 0.8mg/kg/dose SC once per week **Patient Weight:** _____
- ☐Other: _____

☐ **Humira®** (adalimumab) ☐80mg/0.8ml CF Pen ☐ 40mg/0.4ml CF Prefilled Syringe ☐ 40mg/0.4 CF Pen ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 20mg/0.2ml Prefilled Syringe ☐ 10mg/0.1ml Prefilled Syringe
- ☐Initial: Inject 80 mg SC Day 1, then 40mg Day 8, then 40mg every other week thereafter
- ☐Initial: Inject 0.8mg/kg/dose SC weekly x 2 weeks then every 2 weeks
- ☐Maintenance: Inject 40mg SC every two weeks
- ☐Maintenance: 0.8mg/kg/dose every 2 weeks **Patient Weight:** _____
- ☐Other: _____

☐ **Ilumya®** (tildrakizumab) 100mg/ml Prefilled Syringe
- ☐Initial: Inject 100mg SC at weeks 0, 4 and then every 12 weeks thereafter
- ☐Maintenance: Inject 100mg SC every 12 weeks
- ☐Other: _____

☐ **Otezla®** (apremilat)
- ☐ Initial: Take as directed per starter pack
- ☐ Maintenance: Take 30mg by mouth twice daily
- ☐ Other: _____

Quantity Prescribed:_____ **Refills Authorized**:☐ 0 ☐1 ☐2 ☐3 ☐ 6 ☐11 ☐Other: _____ **Please indicate in space provided if brand is necessary by writing DAW:** _____

Physician Signature (no stamps): _____ **Date:** _____

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☐ **Remicade®** (infliximab) 100mg vial OR ☐ **Inflectra®** (infliximab-dyyb) 100mg vial OR ☐ **Renflexis®** (infliximab-abda) 100mg vial OR ☐ **Avsola®** (infliximab-axxq**)** vial
- ☐ Initial: Infuse 5mg/kg IV infusion at weeks 0,2,6, then 5mg/kg IV infusion every 8 weeks
- ☐ Maintenance: Infuse 5mg/kg IV infusion every 8 weeks
- ☐ Other: _____

☐ **Siliq®** (brodalumab) 210 mg/1.5ml Prefilled Syringe
- ☐Initial: Inject 210mg SC at weeks 0,1, and 2 then every 2 weeks thereafter
- ☐Maintenance: Inject 210mg SC every 2 weeks
- ☐Other: _____

☐ **Skyrizi®** (Risankizumab) ☐ 150mg/ml Prefilled Syringe ☐ 150mg/ml Pen
- ☐Initial: Inject 150 mg SC at weeks 0, 4 and then every12 weeks thereafter
- ☐Maintenance: Inject 150 mg SC every 12weeks
- ☐Other: _____

☐ **Sotyktu** (Deucravacitinib) ☐ 6mg tablet
- ☐Take 6mg by mouth once daily

☐ **Stelara®** (ustekinumab) ☐ 45mg Prefilled Syringe (wt<100kg) ☐ 90mg Prefilled Syringe (wt >100kg)
- ☐Initial: Inject SC at weeks 0,4, then every 12 weeks thereafter
- ☐Maintenance: Inject SC every 12 weeks
- ☐ Other: _____

☐ **Taltz®** (ixekizumab) ☐ 80mg/ml Prefilled Syringe OR ☐ 80mg/ml AutoInjector
- ☐Initial: Inject 160 mg SC at week 0, 80 mg SC at weeks 2,4,6,8,10,12 followed by 80mg SC every 4 weeks
- ☐Maintenance: Inject 80 mg SC every 4 weeks
- ☐pediatric dosing >50kg: 160mg week 0 then 80 mg every 4 weeks **Patient Weight:** _____
- ☐pediatric dosing 25-50kg: 80mg week 0 then 40 mg every 4 weeks **Patient Weight:** _____
- ☐pediatric dosing <25kg: 40mg week 0 then 20 mg every 4 weeks **Patient Weight:** _____
- ☐ Other: _____

☐ **Tremfya®** (guselkumab) ☐ 100mg/ml Prefilled Syringe ☐ 100mg/ml One-Press Patient-Controlled Injector
- ☐Initial: Inject 100mg SC at weeks 0, 4 and then every 8 weeks thereafter
- ☐Maintenance: Inject 100mg SC every 8 weeks
- ☐Other: _____

☐ **Xeljanz®** (Tofacitanib) ☐ 5mg Tablet ☐ 10mg Tablet
- ☐Take 1 tablet by mouth 2 times daily

Quantity Prescribed:☐ QS 30 days ☐ Other: ____ **Refills Authorized**:☐ 0 ☐1 ☐2 ☐3 ☐ 6 ☐11 ☐Other: _____ **Please indicate in space provided if brand is necessary by writing DAW:**_____

Physician Signature (no stamps): _____ **Date:** _____