elixir
SPECIALTY PHARMACY

Psoriatic Arthritis 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 OR ☐ 200mg Vials:
- ☐ Inject 200mg SC every other week.
- ☐ Inject 400mg SC once every 4 weeks.
- ☐Other: _____

☐C**osentyx®** (secukinumab) ☐ 150mg Pen Auto injector ☐ 150mg Prefilled Syringe:
- ☐ Initial: Inject SC at weeks 0,1,2,3,4
- ☐ Maintenance: Inject SC every 4 week.
- ☐ Other: _____

☐**Enbrel®** (etanercept) ☐50mg SureClick Pen ☐50mg Mini AutoTouch ☐50mg Prefilled Syringe ☐25mg Prefilled Syringe ☐25mg Vial:
- ☐ Inject 50mg SC once per week.
- ☐Other: _____

☐**Humira®** (adalimumab) ☐ 40mg/0.4ml CF Prefilled Syringe ☐ 40mg/0.4ml CF Pen Autoinjector ☐ 40mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Pen Autoinjector ☐ 80mg/0.8ml CF Pen Autoinjector
- ☐ Inject 40mg SC every two weeks.
- ☐Other: _____

☐ **Orencia®** (golimumab) ☐ 50mg/0.4ml Prefilled Syringe ☐ 87.5mg/0.7ml Prefilled Syringe ☐ 125mg/ml SmartJect Autoinjector ☐ 125mg/ml Prefilled Syringe ☐ 250mg vials
- ☐ 125mg SC every week
- ☐ Initial Infusion:☐1000mg IV over 30 minutes weeks 0, 2, and 4(>100kg) ☐ 750mg IV over 30 minutes at weeks 0, 2,and 4(60-100kg) ☐ 500mg IV over 30 minutes at weeks 0, 2, and 4(<60kg)
- ☐ Maintenance Infusion: ☐ 1000mg IV over 30 minutes every 8 weeks ☐ 750mg IV over 30 minutes every 8 weeks ☐ 500mg IV over 30 minutes every 8 weeks.
- ☐Other: _____
- *******Must provide patient's weight for infusion*******

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

☐ **Remicade®** (infliximab) OR ☐**Avsola® (**infliximab-axxq) OR ☐ **Inflectra®** (infliximab-dyyb) OR ☐ **Renflexis®** (infliximab-abda)
- ☐ 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.
- *********Must provide patient's weight*********

☐ **Rinvoq®** (upadacitinib) ☐ 15mg tablet
- ☐ 15 mg PO once 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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☐ **Skyrizi®** (risankizumab) ☐ 150mg Pen ☐ 150mg Prefilled Syringe
- ☐ 150 mg SC at weeks 0, 4, and then every 12 weeks thereafter
- ☐Other: _____

☐ **Simponi®** (golimumab) ☐ 50mg Prefilled Syringe ☐ 50mg SmartJect Auto injector ☐ 100mg Prefilled Syringe ☐ 100mg SmartJect Auto injector:
- ☐ Inject 50 mg SC once per month.
- ☐ Inject 100mg SC every 4 weeks.
- ☐ Other: _____

☐ **Simponi Aria®** (golimumab) 50mg/4ml
- ☐ Initial: Infuse 2 mg/kg IV at week 0, 4 then every 8 weeks.
- ☐ Maintenance: Infuse 2mg/kg IV infusion every 8 weeks.
- ☐ Other: _____

*******Must provide patient's weight for infusion*******

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

☐ **Taltz®** (ixekizumab) ☐ 80mg/ml Prefilled Syringe OR ☐ 80mg/ml Auto injector
- ☐ Initial: Inject 160 mg SC at week 0 then 80mg SC every 4 weeks.
- ☐ Maintenance: Inject 80 mg SC every 4 weeks starting week 4.
- ☐ Other: _____

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

☐ **Xeljanz®** (tofacitinb): ☐ 5 mg tablet
- ☐5 mg PO twice daily.
- ☐Other:_____

☐ **Xeljanz XR®** (tofacitinib) ☐ 11 mg tablet
- ☐ 11 mg PO once daily.
- ☐ Other:_____

☐ **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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