elixir
SPECIALTY PHARMACY

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

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer Name: _____
Date of Birth: _____ Sex: _____ SS# _____
Address: _____
City: _____State:_____Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of customert's prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone:_____
Policy holder: _____
Policy holder Employer:_____
Relationship to Customer: _____
ID# _____Group#_____
RxBIN: _____RxPCN: _____

Prescriber Information

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

Clinical Information and Prescription

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: _____ NEGATIVE tuberculin skin test? ☐ YES ☐ NO
BSA (Body Surface Area) affected by Psoriasis: _____% Has Hepatitis B been ruled out? ☐ YES ☐ NO
Prior Failed Medications and Date_____
Expected First Dose Date: _____ Injection Instruction needed: ☐YES ☐NO ☐ In-office administration or training

☐ Cimzia® (certolizumab pegol) ☐ Prefilled Syringes OR ☐ Vials ☐ Inject 400 mg SC every other week
☐ Initial: Inject 400 mg SC initially and at weeks 0, 2 and 4, followed by 200 mg every other week (Wt ≤90 kg)
☐ Maintenance: Inject 200 mg SC every other week (Wt ≤90 kg)

☐ Cosentyx® (secukinumab) ☐ Pen Auto injector OR ☐ Prefilled Syringe ☐ 150 mg OR ☐ 300 mg
☐Initial: Inject SC at weeks 0,1,2,3,4, then SC every 4 weeks ☐Maintenance: Inject SC every 4 weeks

☐ Enbrel® (etanercept) ☐50mg SureClick ☐50mg Mini AutoTouch ☐50mg PF Syringe ☐25mg PF 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 ☐Other:_____

☐ Humira® (adalimumab) ☐ 40mg Prefilled Syringe OR ☐ 40mg Pen Auto injector ☐ Requesting citrate/buffer free
☐Initial: Inject 80 mg SC Day 1, then 40mg Day 8, then 40mg every other week thereafter
☐Maintenance: Inject 40mg SC every two weeks ☐Other:_____

☐ Ilumya® (Tildrakizumab) 100mg/ml Prefilled Syringe
☐Initial: Inject SC at weeks 0, 4 and then every 12 weeks thereafter ☐Maintanence: Inject SC every 12 weeks

☐ Otezla® (apremilat) ☐ Initial: Take as directed per starter pack ☐ Maintanence: Take 30mg by mouth twice daily

☐ Remicade® (infliximab) 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

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

☐ Skyrizi® (Risankizumab) 75 mg/0.83 mL Prefilled Syringe ☐Initial: Inject 150 mg SC at weeks 0, 4 and then every 12 weeks thereafter ☐Maintanence: Inject 150 mg SC every 12 weeks thereafter

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

☐ Taltz® (ixekizumab) ☐ 80mg/ml Prefilled Syringe OR ☐ 80mg/ml Auto injector
☐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

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

Quantity Prescribed:☐QS 30 days ☐Other: ____ Refills Authorized:☐ 0 ☐1 ☐2 ☐3 ☐ 6 mos ☐1 yr ☐____

X_____ ____/____/_____
Physician Signature (no stamps) Date