elixir SPECIALTY PHARMACY

Psoriatic Arthritis 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 customer'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.

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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

Psoriatic Arthritis Treatment Selection:

☐ **Cimzia®** (certolizumab pegol) ☐ Prefilled Syringes OR ☐ Vials ☐ Initial Dose: Inject 400 mg SC at weeks 0,2,4
☐ Inject 200mg SC every other week OR ☐ Inject 400mg SC once every 4 weeks

☐ **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
☐ Inject 50mg SC once per week ☐Other:____________________

☐ **Humira®** (adalimumab) ☐ 40mg Prefilled Syringe OR ☐ 40mg Pen Auto injector ☐ Requesting citrate/buffer free
☐ Inject 40mg SC every two weeks ☐Other:____________________

☐ **Orencia®** (golimumab) Inject 50 mg SC once per month ☐ 50mg/0.5ml Syringe ☐ 50mg/0.5ml SmartJect Auto injector

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

☐ **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

☐ **Simponi®** (golimumab) Inject 50 mg SC once per month ☐ Prefilled Syringe ☐ SmartJect Auto injector

☐ **Simponi Aria®** (golimumab) ☐Initial: Infuse 2 mg/kg IV at week 0, 4 then every 8 weeks
☐ Maintenance: Infuse 2mg/kg IV infusion every 8 weeks *Must provide patient's weight

☐ **Stelara®** (ustekinumab) ☐ 45mg Prefilled Syringe (wt<100kg/220 lbs) ☐ 90mg Prefilled Syringe (wt >100kg/220 lbs)
☐ 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

☐ **Xeljanz®** (tofacitinb) 5 mg PO twice daily

☐ **Xeljanz XR®** (tofacitinib) 11 mg PO once daily

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

Physician Signature (no stamps): ____________________ **Date:** ______________

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