Prescription & Enrollment Form

Psoriasis (a-i)

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____
Last name _____ Middle initial _____
Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____
Street address _____ Apt # _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____
Cell phone _____ Other phone _____
E-mail address _____
Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
Insured's name _____
Insured's employer _____ Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: ❑ Yes ❑ No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
Prescriber's first name _____ Last name _____
Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact email _____
Office/clinic/institution name _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

Severity: ❑ Moderate ❑ Moderate to severe ❑ Severe ❑ BSA _____ %
Type: ❑ Plaque ❑ Other _____
Significant symptoms _____
Prior Treatments: ❑ Topicals ❑ PUVA ❑ UVB ❑ Methotrexate ❑ Cyclosporine
❑ Oral retinoids ❑ Other _____
Medical justification for prescribing _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Cimzia® (certolizumab)	❑ 200 mg/mL solution in a single-dose prefilled syringe (PFS) ❑ 200 mg/mL solution in a single-dose PFS Starter Kit ❑ 200 mg/mL lyophilized powder in a single-dose vial for reconstitution	❑ Inject 400 mg subcutaneously every other week. ❑ Inject 400 mg subcutaneously at weeks 0, 2 and 4, followed by 200 mg every other week. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Cosentyx® (secukinumab)	❑ 150 mg/mL solution in a single-use Sensoready pen ❑ 150 mg/mL solution in a single-use PFS ❑ 150 mg lyophilized powder in a single-use vial for reconstitution (for healthcare professional use only)	❑ Inject 300 mg subcutaneously at weeks 0, 1, 2, 3 and 4 followed by 300 mg every 4 weeks. Each 300 mg dose is given as 2 subcutaneous injections of 150 mg. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Enbrel® (etanercept)	❑ 25 mg PFS ❑ 25 mg multiuse vial ❑ 50 mg PFS ❑ 50 mg Mini Cartridge ❑ 50 mg SureClick™	❑ Inject 50 mg subcutaneously once a week. ❑ Inject 50 mg subcutaneously twice a week x 3 months, then 50 mg a week once a week. ❑ Inject _____ mg subcutaneously _____ per week.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Humira® (adalimumab)	**Initial dose:** ❑ 40 mg/0.4 mL citrate-free pens starter package ❑ 40 mg/0.8 mL pens starter package ❑ 80 mg/0.8 mL and 40 mg/0.4 mL citrate-free pens starter package **Maintenance dose:** ❑ 40 mg/0.4 mL citrate-free pen ❑ 40 mg/0.4 mL citrate-free prefilled syringe ❑ 40 mg/0.8 mL pen ❑ 40 mg/0.8 mL prefilled syringe	❑ If new, inject 80 mg initial dose, followed by 40 mg every other week starting one week after initial dose. ❑ If continuing therapy, inject 40 mg subcutaneously every other week. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Ilumya™ (tildrakizumab-asmn)	❑ 100 mg/mL in a single-dose prefilled syringe	❑ Inject 100 mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter. ❑ Inject 100 mg subcutaneously every 12 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed.			Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Psoriasis team at 888.302.1028. To reach your team, call toll-free 844.516.3319.

You can now track shipments for all your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.

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1 PATIENT INFORMATION

❑ New patient ❑ Current

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Last name _____ Middle initial _____

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Street address _____ Apt # _____

City _____ State _____ Zip _____

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Cell phone _____ Other phone _____

E-mail address _____

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

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Insured's employer _____ Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact email _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic

Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

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❑ Oral retinoids ❑ Other _____

Medical justification for prescribing _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Otezla® (apremilast)	❑ Starter Pack (28 day) ❑ 30 mg tablets	❑ **Day 1:** Take by mouth 10 mg in the morning. **Day 2:** Take by mouth 10 mg in the morning and 10 mg in the evening. **Day 3:** Take by mouth 10 mg in the morning and 20 mg in the evening. **Day 4:** Take by mouth 20 mg in the morning and 20 mg in the evening. **Day 5:** Take by mouth 20 mg in the morning and 30 mg in the evening. **Day 6 and thereafter:** Take by mouth 30 mg in the morning and 30 mg in the evening. ❑ **Maintenance dose only:** Take by mouth 30 mg in the morning and 30 mg in the evening. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Siliq™ (brodalumab)	❑ 210 mg/1.5 mL PFS	❑ Inject 210 mg subcutaneously at weeks 0, 1 and 2 followed by 210 mg every 2 weeks. ❑ Inject 210 mg subcutaneously every 2 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Skyrizi™ (risankizumab-rzaa)	❑ 75 mg/0.83mL in a single-dose PFS	❑ Inject 150 mg (two 75 mg injections) subcutaneously at weeks 0, 4 and every 12 weeks thereafter. ❑ Inject 150 mg (two 75 mg injections) subcutaneously every 12 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Stelara® (ustekinumab)	❑ 45 mg/0.5 mL PFS ❑ 90 mg/1 mL PFS	**For patients <100 kg, administer:** ❑ Initial dose of 45 mg SC at week 0 and week 4 followed by: ❑ Maintenance dose of 45 mg SC every 12 weeks. **For patients >100 kg, administer:** ❑ Initial dose of 90 mg SC at week 0 and week 4 followed by: ❑ Maintenance dose of 90 mg SC every 12 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Taltz® (ixekizumab)	❑ 80 mg single-dose autoinjector ❑ 80 mg single-dose PFS	❑ Inject 160 mg (two 80 mg injections) at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10 and 12, then 80 mg every 4 weeks. ❑ Inject 80 mg every 4 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Tremfya™ (guselkumab)	❑ 100 mg/mL single-dose prefilled syringe ❑ 100 mg/mL One-Press patient-controlled injector	❑ Inject 100 mg subcutaneously at weeks 0, 4, and every 8 weeks thereafter ❑ Inject 100 mg subcutaneously every 8 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other			
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed.			Send quantity sufficient for medication days supply

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