Please fax both pages of completed form to the Psoriasis team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Psoriasis (o-z)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact

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

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 address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic 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 retinolds ❑ Other _____

Medical justification for prescribing _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
❑ Otezla® (apremilast)	❑ Starter Pack (28 day) ❑ 30mg tablets	❑ Day 1: Take by mouth 10mg in the morning. Day 2: Take by mouth 10mg in the morning and 10mg in the evening. Day 3: Take by mouth 10mg in the morning and 20mg in the evening. Day 4: Take by mouth 20mg in the morning and 20mg in the evening. Day 5: Take by mouth 20mg in the morning and 30mg in the evening. Day 6 and thereafter: Take by mouth 30mg in the morning and 30mg in the evening. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Siliq™ (brodalumab)	❑ 210mg/1.5mL PFS	❑ Inject 210mg subcutaneously at weeks 0, 1 and 2 followed by 210mg every 2 weeks. ❑ Inject 210mg subcutaneously every 2 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Skyrizi™ (risankizumab-rzaa)	❑ 150mg/mL in each single-dose PFS ❑ 150mg/mL in each single-dose pen	❑ Inject 150mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter. ❑ Inject 150mg subcutaneously every 12 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Stelara® (ustekinumab)	❑ 45mg/0.5mL PFS ❑ 90mg/1mL PFS	**For patients <100kg, administer:** ❑ Initial dose of 45mg subcutaneously at week 0 and week 4 followed by: ❑ Maintenance dose of 45mg subcutaneously every 12 weeks. **For patients >100kg, administer:** ❑ Initial dose of 90mg subcutaneously at week 0 and week 4 followed by: ❑ Maintenance dose of 90mg subcutaneously every 12 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Taltz® (ixekizumab)	❑ 80mg single-dose autoinjector ❑ 80mg single-dose PFS	❑ Inject 160mg (two 80mg injections) subcutaneously at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, then 80mg every 4 weeks. ❑ Inject 80mg subcutaneously every 4 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Tremfya™ (guselkumab)	❑ 100mg/mL single-dose prefilled syringe ❑ 100mg/mL One-Press patient-controlled injector	❑ Inject 100mg subcutaneously at weeks 0, 4, and every 8 weeks thereafter ❑ Inject 100mg 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

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)** **PHYSICIAN SIGNATURE REQUIRED**

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

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.

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