

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)



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 retinoids  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
<input type="checkbox"/> Otezla® (apremilast)	<input type="checkbox"/> Starter Pack (28 day) <input type="checkbox"/> 30mg tablets	<input type="checkbox"/> 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. <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Siliq™ (brodalumab)	<input type="checkbox"/> 210mg/1.5mL PFS	<input type="checkbox"/> Inject 210mg subcutaneously at weeks 0, 1 and 2 followed by 210mg every 2 weeks. <input type="checkbox"/> Inject 210mg subcutaneously every 2 weeks. <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Skyrizi™ (risankizumab-rzaa)	<input type="checkbox"/> 150mg/mL in each single-dose PFS <input type="checkbox"/> 150mg/mL in each single-dose pen	<input type="checkbox"/> Inject 150mg subcutaneously at weeks 0, 4 and every 12 weeks thereafter. <input type="checkbox"/> Inject 150mg subcutaneously every 12 weeks. <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Stelara® (ustekinumab)	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/1mL PFS	<b>For patients &lt;100kg, administer:</b> <input type="checkbox"/> Initial dose of 45mg subcutaneously at week 0 and week 4 followed by: <input type="checkbox"/> Maintenance dose of 45mg subcutaneously every 12 weeks. <b>For patients &gt;100kg, administer:</b> <input type="checkbox"/> Initial dose of 90mg subcutaneously at week 0 and week 4 followed by: <input type="checkbox"/> Maintenance dose of 90mg subcutaneously every 12 weeks. <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Taltz® (ixekizumab)	<input type="checkbox"/> 80mg single-dose autoinjector <input type="checkbox"/> 80mg single-dose PFS	<input type="checkbox"/> 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. <input type="checkbox"/> Inject 80mg subcutaneously every 4 weeks. <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Tremfya™ (guselkumab)	<input type="checkbox"/> 100mg/mL single-dose prefilled syringe <input type="checkbox"/> 100mg/mL One-Press patient-controlled injector	<input type="checkbox"/> Inject 100mg subcutaneously at weeks 0, 4, and every 8 weeks thereafter <input type="checkbox"/> Inject 100mg subcutaneously every 8 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Other			
<input type="checkbox"/> 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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