PHARMACA
SPECIALTY PHARMACY

PSORIASIS ENROLLMENT FORM

Fax: **888.882.3341**
Call: **855.465.8892**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt Phone: _____
Email: _____
DOB: _____ ☐ M ☐ F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: _____ Drug Allergies: ☐ NKDA ☐ _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: _____

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose and Form	Directions	Qty	Refills
☐ **Cimzia**	☐ 200 mg/mL Prefilled Syringe ☐ 200 mg Lyophilized Powder Vial	☐ Inject 400 mg SC every other week	4	
		☐ **Induction:** (< 90 kg) Inject 400 mg SC at weeks 0, 2, and 4	6	0
		☐ **Maintenance:** (< 90 kg) Inject 200 mg SC every other week	2	
☐ **Cosentyx**	☐ 150 mg/mL Sensoready Pen ☐ 150 mg/mL Prefilled Syringe ☐ 150 mg Lyophilized Powder Vial	☐ **Induction:** Inject 150 mg SC at weeks 0, 1, 2, 3, and 4	5	0
		☐ **Induction:** Inject 300 mg SC at weeks 0, 1, 2, 3, and 4	10	0
		☐ **Maintenance:** Inject 150 mg SC every four weeks	1	
		☐ **Maintenance:** Inject 300 mg SC every four weeks	2	
☐ **Enbrel**	☐ 50 mg/mL SureClick Autoinjector ☐ 50 mg/mL Enbrel Mini Prefilled Cartridge for use with the AutoTouch Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ 25 mg Lyophilized Powder Multi-Dose Vial	☐ **Induction:** Inject 50 mg SC twice weekly for 3 months	8	2
		☐ **Maintenance:** Inject 50 mg SC once weekly	4	
		☐ **Pediatric Maintenance:** (< 63 kg) Inject 0.8 mg/kg weekly		
☐ **Humira**	☐ Psoriasis Starter Kit ☐ Hidradenitis Suppurativa Starter Kit ☐ 40 mg/0.4 mL Pen Citrate-free ☐ 40 mg/0.4 mL Prefilled Syringe Citrate-free	☐ **Psoriasis Induction:** Inject 80 mg SC on day 1, then 40 mg SC on day 8, then 40 mg SC every other week	4	0
		☐ **Maintenance:** Inject 40 mg SC every other week	2	
		☐ **Hidradenitis Suppurativa Induction:** Inject 160 mg SC on day 1, then 80 mg SC on day 15, then switch to maintenance dose on day 29	6	0
		☐ **Maintenance:** Inject 40 mg SC every week	4	
☐ **Ilumya**	☐ 100 mg/mL Prefilled Syringe	☐ **Induction:** Inject 100 mg SC at week 0	1	0
		☐ **Maintenance:** Inject 100 mg SC at week 4 and every 12 weeks thereafter	1	
☐ **Orencia**	☐ 125 mg/mL ClickJect Autoinjector ☐ 125 mg/mL Prefilled Syringe	☐ Inject 125 mg SC once weekly	4	
☐ **Otezla**	☐ Starter Pack ☐ 30 mg Tablets	☐ **Initial Titration:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack	1	0
		☐ **Maintenance:** Take one 30 mg tablet by mouth twice daily	60	
☐ **Rasuvo**	☐	☐		
☐ **Simponi**	☐ 50 mg/0.5 mL SmartJect Autoinjector ☐ 50 mg/0.5 mL Prefilled Syringe	☐ Inject 50 mg SC once monthly	1	
☐ **Skyrizi**	☐ 75 mg/0.83 mL Prefilled Syringe	☐ **Induction:** Inject 150 mg (two 75 mg injections) SC at week 0	2	0
		☐ **Maintenance:** Inject 150 mg SC at week 4 and every 12 weeks thereafter	2	
☐ **Stelara**	☐ 45 mg/mL Single-Dose Vial ☐ 45 mg/0.5 mL Prefilled Syringe (< 100kg) ☐ 90 mg/mL Prefilled Syringe (> 100kg)	☐ **Pediatric Induction:** (< 60 kg) Inject 0.75 mg/kg SC on day 1		
		☐ **Induction:** Inject the contents of 1 prefilled syringe SC on day 1	1	0
		☐ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter	1	
☐ **Taltz**	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe	☐ **Induction Step 1:** Inject 160 mg SC at week 0, then 80mg at week 2	3	0
		☐ **Induction Step 2:** Inject 80 mg SC every 2 weeks at weeks 4-10	2	1
		☐ **Maintenance:** Inject 80 mg SC at week 12 and every 4 weeks thereafter	1	
☐ **Tremfya**	☐ 100 mg/mL Prefilled Syringe	☐ **Induction:** Inject 100 mg SC at week 0	1	0
		☐ **Maintenance:** Inject 100 mg SC at week 4 and every 8 weeks thereafter	1	
☐ **Xeljanz**	☐ 5 mg Tablets	☐ Take one tablet by mouth twice daily	60	
☐ **Xeljanz XR**	☐ 11 mg Tablets	☐ Take one tablet by mouth once daily	30	

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

PHYSICIAN SIGNATURE REQUIRED

X _____ X _____

Substitution Permitted | Date | Dispense as Written | Date