

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Shipping Address (if different from home address) <input type="checkbox"/> Ship to MD		Home Phone Number	Work Phone Number
			Date of Birth / /

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis: Psoriasis Plaque Psoriasis Other: _____ Weight: _____ lbs kg Date of Measurement: _____ See Attached

% Body Surface Area (BSA) affected: Mild < 3% Moderate 3% to 10% Severe >10% See Attached

History of: Hepatitis B Cardiac Disease Tuberculosis HIV Does patient have an active infection? Y N

Other: _____ See Attached

Current Medications _____ See Attached

Allergies _____ NKDA

Previous treatment with: NSAID DMARD _____ corticosteroids Biologic DMARD _____ Phototherapy Topical Therapy Dates of Therapy _____ See Attached

If previously treated; reason for discontinuation _____ See Attached

PRESCRIPTION INFORMATION

<input type="checkbox"/> Enbrel 50mg Sureclick Autoinjector or <input type="checkbox"/> Enbrel 25mg Vial <input type="checkbox"/> Enbrel 50mg PFS or <input type="checkbox"/> Enbrel 25mg PFS	<input type="checkbox"/> Humira 40mg Pen Psoriasis Starter Package <input type="checkbox"/> Humira 40mg Pen or <input type="checkbox"/> Humira 40mg PFS
<input type="checkbox"/> Initial Dose: inject 50mg Subcutaneously Twice a week (3-4 days apart) for 3 months, then maintenance dosing <input type="checkbox"/> Maintenance dose: inject 50mg Subcutaneously once a week Quantity: _____ Refill x: _____	<input type="checkbox"/> Starter Pack: inject 80mg (two Pens) Subcutaneously on Day 1 Inject 40mg (one Pen) Subcutaneously on Day 8 Inject 40mg (one Pen) Subcutaneously every other week <input type="checkbox"/> Maintenance Dose: inject 40mg (one pen/PFS) Subcutaneously every other week Quantity: _____ Refill x: _____
<input type="checkbox"/> Remicade 100mg Vial	<input type="checkbox"/> Amevive 7.5mg Vial or <input type="checkbox"/> Amevive 15mg Vial
<input type="checkbox"/> Initial Dose: infuse _____ mg/kg IV at 0, 2 and 6 weeks <input type="checkbox"/> Maintenance Dose: infuse _____ mg/kg IV every _____ weeks Quantity: _____ Refill x: _____	<input type="checkbox"/> infuse 7.5mg IV once a week <input type="checkbox"/> inject 15mg Intramuscularly once a week Quantity: _____ Refill x: _____
<input type="checkbox"/> Stelara 45mg vial or <input type="checkbox"/> Stelara 90mg vial	<input type="checkbox"/> Other:
<input type="checkbox"/> Initial Dose: <input type="checkbox"/> for patients <100kg, inject 45 mg at 0 and 4 weeks then maintenance dosing <input type="checkbox"/> for patients >100kg, inject 90mg at 0 and 4 weeks, then maintenance dosing <input type="checkbox"/> Maintenance Dose: inject _____ mg every 12 weeks Quantity: _____ Refill x: _____	<input type="checkbox"/> Directions: Quantity: _____ Refill x: _____

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Today's Date / /	Date Needed By / /	DEA <input type="checkbox"/> On File	NPI <input type="checkbox"/> On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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