elixir
SPECIALTY PHARMACY

Psoriatic Arthritis Enrollment Form

Fax: 877-309-0687 Phone: 877-437-9012

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ______________________
Date of Birth: ____________ Sex: ______ SS#: ______________
Address: ______________________
City: ______________________ State: ______ Zip: __________
Home Phone: ____________ Work Phone: ______________
Cell Phone: ____________ E-mail: ______________
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______________________
Insurance Company Phone: ______________________
Policy Holder: ______________________
Policy Holder Employer: ______________________
Relationship to Patient: ______________________
ID#: ______________________ Group#: ______________
RxBIN: ______________ RxPCN: ______________

Prescriber Information

Practice/Organization Name: ______________________
Physician Name: ______________________
Address: ______________________
City: ______________________ State: ________ Zip: __________
Phone#: ______________ Fax#: ______________
DEA#: ______________ NPI#: ______________
License#: ______________ Medicaid UPIN#: ______________
Physician Specialty: ______________________
Date Shipment Needed: ______________________
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other**
Shipment Address: ______________________ Attn: __________
City: ______________________ State: ________ Zip: __________
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Diagnosis: ☐ L40.__ Psoriasis ☐ L40.54 Juvenile Psoriatic Arthritis ☐ L40.59 Psoriatic Arthritis ☐ Other:__________
Date of Diagnosis or Years with Disease: ______________ Allergies (☐ NKDA): ______________
Patient Weight: __________ Patient Height: __________ NEGATIVE tuberculin skin test? ☐ YES ☐ NO
BSA (Body Surface Area) affected by Psoriasis: ________% Has Hepatitis B been ruled out? ☐ YES ☐ NO
Prior Failed Medications and Date______________________
Expected First Dose Date: __________ Injection Instruction needed: ☐YES ☐NO ☐ In-office administration or training

Psoriatic Arthritis Treatment Selection:

☐ **Cimzia®** (certolizumab pegol) ☐ Prefilled Syringes OR ☐ Vials ☐ Initial Dose: Inject 400 mg SC at weeks 0,2,4
☐ Inject 200 mg SC every other week OR ☐ Inject 400 mg SC once every 4 weeks

☐ **Cosentyx®** (secukinumab) ☐ Pen Auto injector OR ☐ Prefilled Syringe ☐ 150 mg OR ☐ 300 mg
☐ Initial: Inject SC at weeks 0,1,2,3,4, then SC every 4 weeks ☐ Maintenance: Inject SC every 4 weeks

☐ **Enbrel®** (etanercept) ☐50mg SureClick ☐50mg Mini AutoTouch ☐50mg PF Syringe ☐25mg PF Syringe ☐25mg Vial
☐ Inject 50 mg SC once per week ☐Other:______________________

☐ **Humira®** (adalimumab) ☐ 40 mg Prefilled Syringe OR ☐ 40 mg Pen Auto injector ☐ Requesting citrate/buffer free
☐ Inject 40 mg SC every two weeks ☐Other:______________________

☐ **Orencia®** (abatacept) Inject 50 mg SC once per month ☐ 50 mg/0.5ml Syringe ☐ 50 mg/0.5ml SmartJect Auto injector

☐ **Otezla®** (apremilat) ☐ Initial: Take as directed per starter pack ☐ Maintanence: Take 30 mg by mouth twice per day

☐ **Remicade®** (infliximab) OR ☐**Avsola®** OR ☐**Inflectra®** OR ☐**Renflexis®**
☐ Initial: Infuse 5mg/kg IV infusion at weeks 0,2,6, then 5 mg/kg IV infusion every 8 weeks
☐ Maintenance: Infuse 5 mg/kg IV infusion every 8 weeks *Must provide patient's weight

☐ **Rinvoq®** (upadacitinib) 15 mg PO once daily

☐ **Skyrizi®** (risankizumab) 150 mg SC at weeks 0, 4, and then every 12 weeks thereafter

☐ **Simponi®** (golimumab) Inject 50 mg SC once per month ☐ Prefilled Syringe ☐ SmartJect Auto injector

☐ **Simponi Aria®** (golimumab) ☐Initial: Infuse 2 mg/kg IV at week 0, 4 then every 8 weeks
☐ Maintenance: Infuse 2 mg/kg IV infusion every 8 weeks *Must provide patient's weight

☐ **Stelara®** (ustekinumab) ☐ 45 mg Prefilled Syringe (wt<100kg/220 lbs) ☐ 90 mg Prefilled Syringe (wt >100kg/220 lbs)
☐ Initial: Inject SC at weeks 0,4, then every 12 weeks thereafter ☐ Maintanence: Inject SC every 12 weeks

☐ **Taltz®** (ixekizumab) ☐ 80 mg/ml Prefilled Syringe OR ☐ 80 mg/ml Auto injector
☐ Initial: Inject 160 mg SC at week 0, 80 mg SC at weeks 2,4,6,8,10,12 followed by 80 mg SC every 4 weeks
☐Maintenance: Inject 80 mg SC every 4 weeks

☐ **Tremfya®** (guselkumab) 100 mg/ml ☐ Prefilled Syringe ☐ One-Press Patient-Controlled Injector
☐Initial: Inject SC at weeks 0, 4 and then every 8 weeks thereafter ☐Maintanence: Inject SC every 8 weeks

☐ **Xeljanz®** (tofacitinb) 5 mg PO twice daily

☐ **Xeljanz XR®** (tofacitinib) 11 mg PO once daily

Quantity Prescribed:☐QS 30 days ☐Other: ____ **Refills Authorized:**☐ 0 ☐1 ☐2 ☐3 ☐ 6 ☐11 ☐Other: _____
Physician Signature (no stamps): ______________________ **Date:**______________

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