PSORIASIS AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PraxisRx

PATIENT INFORMATION

Patient:_____ Caregiver: _____
DOB:_____ ☐ Male or ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Allergies:_____
Address:_____ City:_____ State:_____ Zip:_____
Primary Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell
Email:_____

CLINICAL INFORMATION

ICD-10 Code: ☐ L40.0 ☐ L40.5 ☐ L40.8 ☐ L40.9

TB/PPD Test Given? ☐ Yes ☐ No Date of negative TB test: _____

Hep B ruled out? ☐ Yes ☐ No If no, treatment started? ☐ Yes ☐ No

_____% BSA affected by psoriasis Do the affected areas include the palms, soles, head, neck, or genitalia? ☐ Yes ☐ No

Please provide clinical rationale for prescribing this agent:

Prior therapies: _____ Reason for discontinuation: _____

Therapy: ☐ New ☐ Reauthorization Other: _____

PRESCRIPTION INFORMATION

Cimzia® Only for psoriatic arthritis	**Starter Dose:** ☐ Starter Kit (200mg Prefilled Syringes) ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200mg/mL PFS ☐ 3 Kits = 3 cartons of 2 x 200mg Vials	0
	Maintenance Dose: ☐ 200mg/mL Prefilled Syringe ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200mg/mL PFS ☐ 1 Carton = 2 x 200mg Vials	Refills: _____
Enbrel®	☐ 50mg/mL Sureclick® Autoinjector ☐ 50mg/mL Prefilled Syringe ☐ 25mg/mL Prefilled Syringe	**Psoriasis Induction Dose:** ☐ 50mg Sub-Q TWICE a week (72-96 hours apart) x 3 months	☐ 8 Kits	2
		☐ 50mg Sub-Q every week ☐ 25mg Sub-Q TWICE a week	☐ 4 Kits ☐ 2 Kits = 2 Cartons of 4	Refills: _____
Humira®	☐ 40mg/0.8mL Prefilled Auto Pen ☐ 40mg/0.8mL Prefilled Syringes	**Starter Pack for Psoriasis:** ☐ 80mg Sub-Q Day 1, then 40mg every other week, starting 1 week after initial dose	☐ 4 Kits	0
		Maintenance Dose: ☐ 40mg Sub-Q every two weeks	☐ 2 Kits ☐ 4 Kits	Refills: _____
Simponi® Only for psoriatic arthritis	☐ 50mg/0.5mL SmartJect™ Autoinjector ☐ 50mg/0.5mL Prefilled Syringe	☐ 50mg Sub-Q every month	☐ 1 Kit	Refills: _____
Stelara™	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	**Initiation Dose:** ☐ Inject the contents of 1 prefilled syringe Sub-Q initially Day 1	☐ 1 Kit	0
		Maintenance Dose: ☐ Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	☐ 1 Kit	Refills: _____
Remicade®	100mg Lyophilized Vial(s)	☐ __mg IV every two months	☐ __Vial(s)	Refills: _____
Otzela®	**Starter Kit:** (10mg, 20mg & 30mg tablets)	Day 1: 10mg in the AM Day 2: 10mg in the AM and 10mg in the PM Day 3: 10mg in the AM and 20mg in the PM Day 4: 20mg in the AM and 20mg in the PM Day 5: 20mg in the AM and 30mg in the PM	☐ 1 Kit	Refills: _____
	Maintenance Dose: 30mg Tablets	Take 1 tablet twice daily	60 Tablets	Refills: _____

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____
Prescriber: _____ NPI #: _____ Phone #: _____
Fax #: _____ Contact Name: _____
Office Address: _____ City: _____ State: _____ Zip: _____

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: _____ Date: _____