



# PSORIASIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

<b>PATIENT INFORMATION</b>	Patient: _____ Caregiver: _____
	DOB: _____ Male Female Weight: _____ kgs or lbs (check one) Height: _____ in or cm (check one) Recorded Date: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Best Phone #: _____ Cell Alternate Phone #: _____ Cell Email: _____
	Allergies: _____ Latex Allergy: Yes No
	ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

## PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

<b>MEDICAL ASSESSMENT</b>	TB/PPD test given? Yes No Date of negative TB test: _____ Hep B ruled out? Yes No
	If no, treatment started? Yes No
	Does patient have a latex allergy? Yes No _____ % BSA affected by psoriasis
	Do the affected areas include the palms, soles, head, neck, or genitalia? Yes No

Additional justification for drug: _____	<b>PRIOR (FAILED) THERAPY:</b> Enbrel Humira Simponi Stelara Methotrexate PUVA UVB Topicals (please list): _____ Other (please list): _____
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## PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Cimzia® (certolizumab)  Only for psoriatic arthritis Enroll in Cimzia® Connect	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	_____
Cosentyx® (secukinumab)  Enroll in Cosentyx® Connect	Starter Dose: 5 x 150mg/mL 10 x 150mg/mL	150 mg SQ at week 0, 1, 2, 3 and 4 300 mg SQ at week 0, 1, 2, 3 and 4	_____ Pen OR _____ PFS	0
	Maintenance Dose: 1 x 150mg/mL 2 x 150mg/mL	150 mg SQ every 4 weeks 300 mg SQ every 4 weeks	_____ Pen OR _____ PFS	_____
Dupixent® (dupilumab)  Enroll in Dupixent® MyWay	Starter Dose: 2 x 300mg/2 mL	600 mg SQ on day 1	1 x PFS	0
	Maintenance Dose: 1 x 300mg/2 mL	300 mg SQ every other week	_____ PFS	_____
Enbrel® (etanercept)  Enroll in Enbrel® Support  Enroll in Enbrel® Nurse Partner	Psoriasis Starter Dose: 8 x 50mg/mL x 3 months	50 mg SQ TWICE a week (72-96 hours apart) x 3 months	8 Sureclick Autoinjectors, OR 8 PFS	2
			8 Mini Cartridge Solution for Injection	2
	Maintenance Dose: 4 x 50mg/mL 8 x 25mg/mL	50 mg SQ every week 25 mg SQ TWICE a week	4 Sureclick Autoinjectors, OR 4 PFS  4 Mini Cartridge Solution for Injection 8 x25mg PFS OR 8 x25mg Vials	_____ _____
Humira® (adalimumab)  Enroll in Humira® Complete	Psoriasis Starter Dose: 4 x 40mg/0.8mL Pen	80 mg SQ day 1, then 40 mg every other week, starting 1 week after initial dose	4 Pens OR 4 PFS	0
	Hidradenitis Suppurativa Starter: 6 x 40mg/0.8mL	160 mg SQ day 1, then 80 mg on day 15, then 40 mg weekly starting on day 29	6 Pens OR 6 PFS	0
	Maintenance Dose: 2 x 40mg/0.8mL 4 x 40mg/0.8mL	40 mg SQ every two weeks 40 mg SQ every week	2 Pens OR 2 PFS 4 Pens OR 4 PFS	_____ _____
Otezla® (apremilast)  Enroll in Otezla® Support Enroll in Otezla® Starter Kit Received	Starter Dose: 28 days titrating dose Other _____	per manufacturer titrating dosing schedule _____	1 pack	0
	Maintenance Dose: 60 x 30mg tablets	30 mg po twice daily	_____ pack of 60 tabs	_____



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		MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
PRESCRIPTION INFORMATION	Remicade® (infliximab) Inflixtra Renflexis Enroll in CarePath®	Starter Dose: 5mg/kg	_____ mg IV infusion at weeks 0, 2, and 6	_____ Vial(s)	0	
		Maintenance Dose: 100mg Lyophilized Vial(s)	_____ mg IV every 8 weeks	_____ Vial(s)	_____	
	Simponi® (golimumab) Only for psoriatic arthritis Enroll in CarePath®	1 x 50mg/0.5mL	50 mg SQ every month	_____ SmartJect Autoinjector OR _____ PFS	_____	
	Stelara™ (ustekinumab) Enroll in CarePath®	45mg/0.5mL Prefilled Syringe 90mg/1mL Prefilled Syringe	Initiation Dose: Inject the contents of 1 prefilled syringe Sub-Q initially Day 1	1	0	
			Maintenance Dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	1	_____	
	Skyrizi	150mg Pen 150mg Prefilled Syringe	Initiation Dose: Inject 150mg subcutaneously at Week 0, Week 4, and every 12 weeks thereafter	_____	_____	
			Maintenance Dose: Inject 150mg subcutaneously every 12 weeks	_____	_____	
	Taltz® (ixekizumab) Enroll in Taltz® Savings Program	Starter Dose: 2 x 80mg/mL 6 x 80mg/mL	160 mg SQ at week 0 80 mg SQ at weeks 2, 4, 6, 8, 10, 12	2 PFS OR 2 AutoInject 6 PFS OR 6 AutoInject	0 0	
		Maintenance Dose: 1 x 80mg	80 mg SQ every 4 weeks	_____ PFS OR _____ AutoInject	0	
	Tremfya® (guselkumab) Jenssen CarePath®	Starter Dose: 2 x 100mg/mL	100 mg SQ at weeks 0 and 4	2 PFS	_____	
Maintenance Dose: 1 x 100mg		100 mg SQ at week 8	_____ PFS	_____		
Other				_____		

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