

**Psoriasis  
Psoriatic Arthritis  
Prescription &  
Pharmacy Intake Form**



**Phone: 1-718-762-7400  
Fax: 1-718-762-7404  
Toll Free: 1-888-93-EVERS**

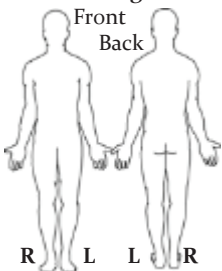
Provider Representative | Phone \_\_\_\_\_ Date Needed \_\_\_\_\_ Ship to  Specialty Care Center  Patient's Home  
 Prescriber's Office  Other \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Insurance Provider (Please include copy of front and back of card): \_\_\_\_\_  
ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Employer: \_\_\_\_\_  
Relationship to Patient:  Self  Other: \_\_\_\_\_  Patient is Eligible for Medicare  
Prescription Card:  Yes  No Carrier: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

**CLINICAL ASSESSMENT**

Patient is New to Therapy  
 Patient is Currently on Therapy (Start Date: \_\_\_\_\_)  
Primary ICD-9 Code and Condition:  
 696.1 Psoriasis  696.0 Psoriatic Arthritis  
 Other \_\_\_\_\_  
Date of Diagnosis/Years with Disease: \_\_\_\_\_  
\_\_\_\_\_ % BSA affected by Psoriasis  
 Symptoms Present  $\geq$  1 year  
Severity:  
 Moderate  
 Moderate to Severe  
 Severe  
# of Tender Joints: \_\_\_\_\_  
# of Swollen Joints: \_\_\_\_\_  
TB Test Result & Date: \_\_\_\_\_  
 New Amevive® Therapy Start  
 Continuing Therapy  Amevive® Restart  
Date of Last Injection: \_\_\_\_\_  
T-Cell Count: \_\_\_\_\_ T-Cell Test Date: \_\_\_\_\_  
 At least 250 CD4 T-Cell Count  
 Inadequate Response to Standard Systemic Agents  
 Inadequate Response to Standard Phototherapy  
Current Weight: \_\_\_\_\_ Date: \_\_\_\_\_  
Allergies: \_\_\_\_\_



**PRESCRIPTION INFORMATION**

Medication	Dose/Directions/Freq	Qty	Re ls
<b>Amevive® (alefacept)</b> <input type="checkbox"/> Four 15 mg/mL Dose Carton <input type="checkbox"/> One 15 mg/mL Dose Carton			
<b>Enbrel® (etanercept)</b> <input type="checkbox"/> 25 mg Prefilled Syringe <input type="checkbox"/> 25 mg Vial <input type="checkbox"/> 50 mg Prefilled Syringe <input type="checkbox"/> 50 mg SureClick™ Pen			
<b>Humira® (adalimumab)</b> <input type="checkbox"/> Starter Kit (4) 40 mg Pens <input type="checkbox"/> 40 mg Prefilled Syringe <input type="checkbox"/> 40 mg Prefilled Pen			
<b>Remicade®</b> <input type="checkbox"/> 100 mg Vial			
<b>Simponi™</b> <input type="checkbox"/> 50 mg SmartJect™ AutoInjector <input type="checkbox"/> 50 mg Prefilled Syringe			
<b>Stelara™</b> <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe			
<input type="checkbox"/> Other: _____			

**PRESCRIBER INFORMATION**

Prescriber's Name: \_\_\_\_\_ Practice/Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI#: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_  
In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: \_\_\_\_\_  
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.  
Prescriber's Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.  
**IMPORTANT WARNING:** This is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employer or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.  
Drug names are the property of their respective owners.