

**FAX REFERRAL TO: 800-447-3694**  
**Phone: 800-990-9247**

**Date:** \_\_\_\_\_ **Needs by Date:** \_\_\_\_\_      •Ship to  Patient  Office  Training at PharmaCare

**PATIENT INFORMATION**

(Complete the following *or send patient demographic sheet*)

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Alternate Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Name: \_\_\_\_\_  
State License #: \_\_\_\_\_ DEA#: \_\_\_\_\_  
Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance/  
Prescription Card:

PLEASE FAX COPY OF INS CARD  
(FRONT & BACK)

Secondary Insurance/  
Prescription Card:

PLEASE FAX COPY OF INS CARD  
(FRONT & BACK)

**CLINICAL INFORMATION**

*(OPTIONAL – but will assist in insurance authorization and patient education)*

**Diagnosis:**

- 696.1 Psoriasis  
 696.0 Psoriatic Arthritis  
 Other: \_\_\_\_\_

**Other Clinical Info:**

- Does patient have a latex allergy?  
 Yes  No
- TB/PPD Test Given?  
 Yes  No
- \_\_\_\_\_ % BSA (body surface area) affected by Psoriasis
- Weight: \_\_\_\_\_ kg or \_\_\_\_\_ lb
- Other Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prior (FAILED) Medications:**

	<i>Medication</i>	<i>Strength</i>	<i>Duration of Treatment/Reason for Discontinuation</i>
<b>Biologics</b>	<input type="checkbox"/> Adalimumab	_____	_____
	<input type="checkbox"/> Alefacept	_____	_____
	<input type="checkbox"/> Etanercept	_____	_____
	<input type="checkbox"/> Efalizumab	_____	_____
<b>Oral Meds</b>	<input type="checkbox"/> Acitretin	_____	_____
	<input type="checkbox"/> Corticosteroids (oral)	_____	_____
	<input type="checkbox"/> Cyclosporine	_____	_____
	<input type="checkbox"/> Methotrexate	_____	_____
	<input type="checkbox"/> NSAID: _____	_____	_____
<b>Topical Meds</b>	<input type="checkbox"/> Sulfasalazine	_____	_____
	<input type="checkbox"/> Calcipotriene	_____	_____
	<input type="checkbox"/> Corticosteroids (top.)	_____	_____
<b>Phototherapy</b>	<input type="checkbox"/> Tazarotene	_____	_____
	<input type="checkbox"/> PUVA	_____	_____
	<input type="checkbox"/> UVB	_____	_____
<b>OTHER</b>	<input type="checkbox"/>	_____	_____

**PRESCRIPTION INFORMATION**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml Sureclick™ Autoinj.	<input type="checkbox"/> Inject 50mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> Inject 25mg SC TWICE a week	4-week supply	_____
	<input type="checkbox"/> 50mg/ml Prefilled Syringe			
	<input type="checkbox"/> 25mg Vial (supplies included)			
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8ml Pen	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week	4-week supply	_____
	<input type="checkbox"/> 40mg/0.8ml Prefilled Syringe			
<input type="checkbox"/> Raptiva®	125mg/1.25ml Vial	Inject _____ ml SC the first week as a conditioning starter dose, then inject _____ ml ONCE a week thereafter	4-week supply	_____
<input type="checkbox"/> Amevive®	15mg/0.5ml Vial (supplies included.)	Inject 15mg (0.5ml) IM ONCE a week for 12 weeks	4-week supply	_____
<input type="checkbox"/>				

**Patient Support Programs:**

I authorize PharmaCare Specialty Pharmacy to enroll me in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize PharmaCare to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to PharmaCare Pharmacy, Privacy Office, 600 Penn Center Blvd. Pittsburgh, PA 15235. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.

• Patient Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_  Enliven (Enbrel®)  My Humira®

\_\_\_\_\_  
Prescriber Signature

Do not Substitute