

# Twin Oaks Specialty Pharmacy

Fax: 855-909-TOSP (8677)

# PSORIATIC ARTHRITIS ENROLLMENT

## O - Z

Date Medication Needed: \_\_\_\_\_ Ship To: Patient's Home Prescriber's Office Pick-up (store location): \_\_\_\_\_ Injection training by pharmacy?

**1: Patient Information** Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. kg.  
 Soc. Sec. #: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_

**2: Prescriber Information**

Provider Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Key Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**3: Clinical information:** Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Plaquenil	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Sulfasalazine	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Meloxicam	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Naproxen / Aleve	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis)  L40.52 Psoriatic Arthritis Mutilans  
 L40.59 Other Psoriatic Arthropathy  Other: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_ Allergies: \_\_\_\_\_  
 Active TB is ruled out:  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hep B ruled out/treated:  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Additional Clinical Information: \_\_\_\_\_

**4: Prescription information**

Drug		Directions & Quantity	Refills
<b>Orencia®</b>	<input type="checkbox"/> Vials <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> ClickJect™	<b>INTRAVENOUS (IV):</b> <input type="checkbox"/> INITIAL: Infuse _____ mg via IV on week 0, 2, and 4(Quantity: ____) <input type="checkbox"/> MAINTENANCE: Infuse _____ mg via IV every 4 weeks (Quantity: ____) <b>SUBCUTANEOUS (SQ):</b> <input type="checkbox"/> Inject 125mg SQ once weekly (Quantity: 4)	
<b>Otezla®</b>	<input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> Maintenance <input type="checkbox"/> Bridge Dose Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 55) <input type="checkbox"/> 14 day titration starter pack sample provided by MD office <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 60) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 30) <b>Continuation of Therapy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 28) (12 refills) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 28) (6 refills)	
<b>Simponi®</b>	<input type="checkbox"/> SmartJect® (Pen) <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Inject 50 mg SQ once a month (Quantity: 1)	
<b>Stelara®</b>	<input type="checkbox"/> Pre-filled Syringe Weight Required: _____	<input type="checkbox"/> INITIAL: Inject 45 mg SQ on Day 0 & Day 28 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 45 mg SQ every 12 weeks (Quantity: 1) <input type="checkbox"/> INITIAL: Inject 90 mg SQ on Day 0 & Day 28 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ every 12 weeks (Quantity: 1)	<b>***WEIGHT BASED GUIDELINES:***                  Less than or equal to 100 kg (220 lbs): 45 mg                  Greater than 100 kg (220 lbs): 90mg</b>
<b>Taltz®</b>	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ on week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> STARTING: Inject 160 mg SQ on week 0 (Quantity: 2) <input type="checkbox"/> INDUCTION: Inject 80 mg SQ every 2 weeks (weeks 2-12) (Quantity: 2 plus 2 refills) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (after 12 weeks) (Quantity: 1)	
<b>Xeljanz®</b>	5 mg Tablets	<input type="checkbox"/> Take 5 mg PO twice daily (Quantity: 60)	
<b>Xeljanz® XR</b>	11 mg Tablets	<input type="checkbox"/> Take 11 mg PO once daily (Quantity: 30)	

**Patient:** By signing this form, patient agrees to release his/her PHI to Twin Oaks Specialty Pharmacy for the purpose of medical and pharmaceutical treatment as per HIPAA compliance and to enroll in the pharmaceutical company assisted patient support programs. **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescriber Signature:** By signing this form, and utilizing our services, you are also authorizing Twin Oak Specialty Pharmacy to serve as your designated agent in dealing with medical and prescription insurance companies and co-pay assistance foundations. \_\_\_\_\_ **Date:** \_\_\_\_\_

Dispense as written \_\_\_\_\_ Date \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date: \_\_\_\_\_