Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Twin Oaks Specialty Pharmacy

Fax: 855-909-TOSP (8677)

PSORIATIC ARTHRITIS ENROLLMENT
A - N

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:**
☐ Methotrexate	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ 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
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)		
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10)	☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Cosentyx™ Covered Until You're Covered	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10)	☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐25 mg ☐50 mg ☐ Vials 25 mg	☐ Inject 50 mg SQ every week (Quantity: 4) ☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)		
Humira®	☐ Pen ☐0.8ml ☐ 0.4ml ☐ Pre-filled Syringe	☐Inject 40 mg SQ every **other** week (Quantity: 2)		
Other				

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.

Dispense as written Date Substitution Permissable **Date:**