

Updated July 2019

Patient Name _____ Today's Date _____ NEW Patient CURRENT Patient
 DOB _____ Height _____ Weight _____ Male Female Preferred Language _____
 Best Phone _____ Email _____
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Ship to Patient at: Home Physician Office Work Address _____
 Allergies _____
 Current Medications including OTC's (please fax a complete list) _____

Please Fax Insurance Card(s) both sides

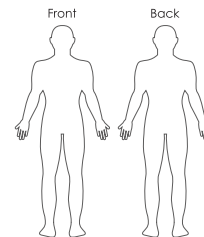
Insured's Name _____
 Relation to Patient _____
Primary Insurance _____
 ID# _____ Group # _____
Secondary Insurance _____
 ID# _____ Group # _____

Ordering Prescriber

Office Contact _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____
 Email _____
 License# _____
 NPI# _____

ICD-10 Code **L40.8** Psoriasis **L40.59** Psoriatic Arthritis **M45.9** Ankylosing Spondylitis
 Yes No Currently on therapy?
 Yes No Active TB ruled out? Date _____
 Yes No Active Hep B ruled out? Date _____
 Methotrexate contraindicated? Yes No Due to social activities?
 Yes No Because Patient is of childbearing age?

| Previous Meds | Strength | Duration of Treatment | Not Tolerated | Contraindications |
|------------------|----------|-----------------------|---------------|-------------------|
| Acitretin | _____ | _____ | _____ | _____ |
| Adalimumab | _____ | _____ | _____ | _____ |
| Clobetasol | _____ | _____ | _____ | _____ |
| Cyclosporine | _____ | _____ | _____ | _____ |
| Elidel | _____ | _____ | _____ | _____ |
| Enbrel | _____ | _____ | _____ | _____ |
| Eucrisa | _____ | _____ | _____ | _____ |
| Humira | _____ | _____ | _____ | _____ |
| Leflunomide | _____ | _____ | _____ | _____ |
| Methotrexate | _____ | _____ | _____ | _____ |
| Stelara | _____ | _____ | _____ | _____ |
| Sulfasalazine | _____ | _____ | _____ | _____ |
| UVA Phototherapy | _____ | _____ | _____ | _____ |
| UVB Phototherapy | _____ | _____ | _____ | _____ |



Scoring Tool Used:
 BSA EASI ISGA
 POEM SCORAD
 _____% or Score: _____
Severity:
 Mild (<3% BSA)
 Moderate (3-10% BSA)
 Severe (>10% BSA)

Location/Affected Areas:

Scalp Face Hands Nails
 Groin Feet Other _____

PRESCRIPTION

New York Prescribers, please submit prescription on an original NY State prescription blank.

COSENTYX FOR PLAQUE PSORIASIS

Starting Dose Sensoready® Pen Prefilled Syringe
 Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
 SIG: Inject 300 mg dose SQ once weekly for 5 weeks
 Each 300 mg dose is given as 2 SQ injections of 150 mg
 QTY: 10 injection devices Refills: 0
 Treatment Start Date (if applicable) _____

Maintenance Supply Sensoready® Pen Prefilled Syringe
 Once every 4 weeks
 SIG: Inject 300 mg dose SQ once every 4 weeks
 Other: _____
 1 Month 2 Months 3 Months
 QTY: _____ Refills: _____

COSENTYX FOR PSORIATIC ARTHRITIS & ANKYLOSING SPONDYLITIS

With Loading Dose Sensoready® Pen Prefilled Syringe
 Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
 SIG: Inject 150 mg dose SQ once weekly for 5 weeks
 QTY: 10 injection devices Refills: 0
 Treatment Start Date (if applicable) _____

Without Loading Dose Sensoready® Pen Prefilled Syringe
 SIG: Inject 150 mg dose SQ once every 4 weeks
 Other: _____
 1 Month 2 Months 3 Months
 QTY: _____ Refills: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
 My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.