DR IKE'S SPECIALTY PHARMACY

Psoriatic Arthritis
ENROLLMENT FORM A-M

P: 818.578.7400 | F: 888-804-7717 | www.drikesp.com | NPI: 1154712305

1 Prescriber Information

Practice Name: _____ Tax ID: _____

Prescriber Practitioner: _____ NPI: _____

Supervising Physician: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

(Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Dr. Ike's Specialty Care.)

2 Patient Information *(This prescription form is to be sent and received via fax.)*

Name: _____ DOB: _____ SS#: _____ ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ ☐ English ☐ Spanish ☐ Other Wt. _____ Ht. _____

3 Prescription

☐ New ☐ Refill SHIP BY: _____ SHIP TO: ☐ PATIENT'S HOME ☐ DOCTOR'S OFFICE ☐ OTHER: _____

DRUG		DIRECTIONS & QUANTITY		REFILLS
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ INITIAL: Inject 400 mg SQ on 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)*	☐ MAINTENANCE: Inject 150 mg SQ every 4 weeks *(Quantity: 1)*	
		☐ INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3 and 4 *(Quantity: 10)*	☐ MAINTENANCE: Inject 300 mg SQ every 4 weeks *(Quantity: 2)*	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐ 25mg ☐ 50mg ☐ Vials 25mg	☐ Inject 50 mg SQ every week *(Quantity: 4)* ☐ Inject 25 mg SQ twice weekly 72-96 hours apart *(Quantity: 8)*		
Humira® *(Citrate Free)*	☐ Pen ☐ Pre-filled Syringe	☐ Inject 40 mg SQ once every 2 weeks *(Quantity: 2)*		
Humira®	☐ Pen ☐ Pre-filled Syringe	☐ Inject 40 mg SQ once every 2 weeks *(Quantity: 2)*		

4 Medical Information *(Please fax copy of prescription/medical card, front and back, as well as any clinical notes regarding therapy.)*

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:
☐ Cimzia	☐ _____	☐
☐ Enbrel	☐ _____	☐
☐ Humira	☐ _____	☐
☐ Meloxicam	☐ _____	☐
☐ Methotrexate	☐ _____	☐
☐ NSAID	☐ _____	☐
☐ Plaquenil	☐ _____	☐
☐ Sulfasalazine	☐ _____	☐
☐ Other _____	☐ _____	☐

☐ 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: _____

To Prescribing Practitioner: *By signing this form and utilizing our services, you are also authorizing Dr. Ike's Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.*

Prescriber's Signature: _____ Date: _____

DR IKE'S SPECIALTY PHARMACY

Psoriatic Arthritis ENROLLMENT FORM N-Z

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2 Patient Information

(This prescription form is to be sent and received via fax.)

Name: _____ DOB: _____ SS#: _____ ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ ☐ English ☐ Spanish ☐ Other Wt. _____ Ht. _____

3 Prescription

☐ New ☐ Refill SHIP BY: _____ SHIP TO: ☐ PATIENT'S HOME ☐ DOCTOR'S OFFICE ☐ OTHER: _____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Orencia®	☐ 250mg Vials ☐ Pre-filled Syringe ☐ ClickJect™	**INTRAVENOUS (IV):** ☐ INITIAL: Infuse _____ mg via IV on weeks 0, 2 and 4 *(Quantity: QS 3 doses)* ☐ MAINTENANCE: Infuse _____ mg via IV every 4 weeks *(Quantity: QS 1 dose)* **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly *(Quantity: 4)*	
Otezla®	☐ 28 Day Starter Pack ☐ Maintenance	☐ Take as directed per package instruction *(Quantity: 55)* ☐ Take 30mg PO twice daily *(Quantity: 60)*	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50mg SQ once a month *(Quantity: 1)*	
Simponi Aria®	☐ 50mg Vial Weight: _____ Height: _____	☐ INITIAL: Infuse 2mg/kg via IV over 30 minutes on weeks 0 and 4 *(Quantity: QS 2 doses)* ☐ MAINTENANCE: Infuse 2mg/kg via IV over 30 minutes every 8 weeks *(Quantity: QS 1 dose)*	
Stelara®	☐ Pre-filled Syringe Weight: _____	☐ INITIAL: Inject 45mg SQ on weeks 0 and 4 *(Quantity: 2)* ☐ MAINTENANCE: Inject 45mg SQ every 12 weeks *(Quantity: 1)* ☐ INITIAL: Inject 90mg SQ on weeks 0 and 4 *(Quantity: 2)* ☐ MAINTENANCE: Inject 90mg SQ every 12 weeks *(Quantity: 1)*	
Taltz®	☐ Auto Injector ☐ Pre-filled Syringe	☐ INITIAL: Inject 160mg (2 x 80mg) SQ on week 0 *(Quantity: QS 2 doses)* ☐ MAINTENANCE: Inject 80mg SQ every 4 weeks *(Quantity: QS 1 dose)* ☐ STARTING: Inject 160 mg (2 x 80 mg) SQ on week 0, then begin first induction dose 80 mg (1 x 80 mg) 2 weeks later (week 2) *(Quantity: 3)* ☐ INDUCTION: Inject 80 mg SQ every 2 weeks (weeks 4-10) *(Quantity: 2 plus 1 refill)* ☐ FINAL INDUCTION: Inject 80 mg SQ (week 12) *(Quantity: 1)* ☐ MAINTENANCE: Inject 80 mg SQ every 4 weeks *(Quantity: 1)*	
Tremfya®	☐ One-Press Injector ☐ Pre-filled Syringe	☐ INITIAL: Inject 100mg SQ on weeks 0 and 4 *(Quantity: 2)* ☐ MAINTENANCE: Inject 100mg SQ every 8 weeks *(Quantity: 1)*	
Xeljanz®	☐ 5mg Tablets	☐ Take 5mg PO twice daily *(Quantity: 60)*	
Xeljanz® XR	☐ 11mg Tablets	☐ Take 11mg PO once daily *(Quantity: 30)*	

4 Medical Information

(Please fax copy of prescription/medical card, front and back, as well as any clinical notes regarding therapy.)

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:
☐ Enbrel	☐ _____	☐
☐ Humira	☐ _____	☐
☐ Methotrexate	☐ _____	☐
☐ NSAID	☐ _____	☐
☐ Sulfasalazine	☐ _____	☐
☐ Other _____	☐ _____	☐

☐ 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: _____

To Prescribing Practitioner: *By signing this form and utilizing our services, you are also authorizing Dr. Ike's Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.*

Prescriber's Signature: _____ Date: _____