PSORIASIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: ______ Caregiver: ______

DOB: ______ Male Female Weight: ______ kgs or lbs (check one) Height: ______ in or cm (check one) Recorded Date: ______

Address: ______ City: ______ State: ______ Zip: ______

Best Phone #: ______ Cell Alternate Phone #: ______ Cell Email: ______

Allergies: ______ Latex Allergy: Yes No

ICD-10 Code for requested therapy: ______ ICD-10 Code(s) for other medical conditions: ______

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

TB/PPD test given? Yes No Date of negative TB test: ______ Hep B ruled out? Yes No

If no, treatment started? Yes No

Does patient have a latex allergy? Yes No

______% BSA affected by psoriasis

Do the affected areas include the palms, soles, head, neck, or genitalia? Yes No

Additional justification for drug: ______

______

PRIOR (FAILED) THERAPY:

Enbrel Humira Simponi Stelara

Methotrexate PUVA UVB

Topicals (please list): ______

Other (please list): ______

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Cimzia® (certolizumab) Only for psoriatic arthritis Enroll in Cimzia® Connect	Starter Dose: Starter Kit (200mg Prefilled Syringes) 200mg Lyophilized Vial	400mg Sub-Q at weeks 0, 2, and 4	1 Kit = 6 x 200mg/mL PFS 3 Kits = 3 cartons of 2 x 200mg Vials	0
	Maintenance Dose: 200mg/mL Prefilled Syringe 200mg Lyophilized Vial	400mg Sub-Q every 4 weeks 200mg Sub-Q every 2 weeks	1 Carton = 2 x 200mg/mL PFS 1 Carton = 2 x 200mg Vials	______
Cosentyx® (secukinumab) Enroll in Cosentyx® Connect	Starter Dose: 5 x 150mg/mL 10 x 150mg/mL	150 mg SQ at week 0, 1, 2, 3 and 4 300 mg SQ at week 0, 1, 2, 3 and 4	______Pen OR ______ PFS	0
	Maintenance Dose: 1 x 150mg/mL 2 x 150mg/mL	150 mg SQ every 4 weeks 300 mg SQ every 4 weeks	______Pen OR ______ PFS	______
Dupixent® (dupilumab) Enroll in Dupixent® MyWay	Starter Dose: 2 x 300mg/2 mL	600 mg SQ on day 1	1 x PFS	0
	Maintenance Dose: 1 x 300mg/2 mL	300 mg SQ every other week	______ PFS	______
Enbrel® (etanercept) Enroll in Enbrel® Support Enroll in Enbrel® Nurse Partner	Psoriasis Starter Dose: 8 x 50mg/mL x 3 months	50 mg SQ TWICE a week (72-96 hours apart) x 3 months	8 Sureclick Autoinjectors, OR 8 PFS	2
			8 Mini Cartridge Solution for Injection	2
	Maintenance Dose: 4 x 50mg/mL 8 x 25mg/mL	50 mg SQ every week 25 mg SQ TWICE a week	4 Sureclick Autoinjectors, OR 4 PFS	______
			4 Mini Cartridge Solution for Injection 8 x25mg PFS OR 8 x25mg Vials	______
Humira® (adalimumab) Enroll in Humira® Complete	Psoriasis Starter Dose: 4 x 40mg/0.8mL Pen	80 mg SQ day 1, then 40 mg every other week, starting1 week after initial dose	4 Pens OR 4 PFS	0
	Hidradentitis Suppurativa Starter: 6 x 40mg/0.8mL	160 mg SQ day 1, then 80 mg on day 15, then 40 mg weekly starting on day 29	6 Pens OR 6 PFS	0
	Maintenance Dose: 2 x 40mg/0.8mL 4 x 40mg/0.8mL	40 mg SQ every two weeks 40 mg SQ every week	2 Pens OR 2 PFS 4 Pens OR 4 PFS	______
Otezla® (apremilast) Enroll in Otezla® Support Enroll in Otezla® Starter Kit Received	Starter Dose: 28 days titrating dose Other ______	per manufacturer titrating dosing schedule ______	1 pack	0
	Maintenance Dose: 60 x 30mg tablets	30 mg po twice daily	______ pack of 60 tabs	______

(Continued on page 2)

PSORIASIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

Patient: ______________________________________ DOB: _____________

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Remicade® (infliximab) Inflectra Renflexis Enroll in CarePath®	Starter Dose: 5mg/kg	_______ mg IV infusion at weeks 0, 2, and 6	_______ Vial(s)	0
	Maintenance Dose: 100mg Lyophilized Vial(s)	_______ mg IV every 8 weeks	_______ Vial(s)	______
Simponi® (golimumab) Only for psoriatic arthritis Enroll in CarePath®	1 x 50mg/0.5mL	50 mg SQ every month	_______ SmartJect Autoinjector OR _______ PFS	______
Stelara™ (ustekinumab) Enroll in CarePath®	45mg/0.5mL Prefilled Syringe 90mg/1mL Prefilled Syringe	Initiation Dose: Inject the contents of 1 prefilled syringe Sub-Q initially Day 1	1	0
		Maintenance Dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	1	______
Skyrizi	150mg Pen 150mg Prefilled Syringe	Initiation Dose: Inject 150mg subcutaneously at Week 0, Week 4, and every 12 weeks thereafter	_______	______
		Maintenance Dose: Inject 150mg subcutaneously every 12 weeks	_______	
Taltz® (ixekizumab) Enroll in Taltz® Savings Program	Starter Dose: 2 x 80mg/mL 6 x 80mg/mL	160 mg SQ at week 0 80 mg SQ at weeks 2, 4, 6, 8, 10, 12	2 PFS **OR** 2 AutoInject 6 PFS **OR** 6 AutoInject	0 0
	Maintenance Dose: 1 x 80mg	80 mg SQ every 4 weeks	_______ PFS **OR** _______ AutoInject	0
Tremfya® (guselkumab) Jenssen CarePath®	Starter Dose: 2 x 100mg/mL	100 mg SQ at weeks 0 and 4	2 PFS	______
	Maintenance Dose: 1 x 100mg	100 mg SQ at week 8	_______ PFS	______
Simlandi® (adalimumab-ryvk)	40mg/0.4mL (PEN) 40mg/0.4mL (PFS)			______
Other				______

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (800)-641-8475 to obtain instructions as to the proper destruction of the transmitted material.

©2025. HealthDyne® is a servicemark of HealthDyne, LLC.