SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

Psoriasis Enrollment

Patient Information

Date:_____ Patient SS#:_____ DOB:_____ ☐ Male ☐ Female
Patient's First Name:_____ Patient's Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone #:_____ Alternate Phone #:_____
Weight:_____ Caregiver:_____ Allergies:_____
TB/PPD Test Given? ☐ **Yes** ☐ **No** **Date of negative TB test:** ___ **Hep B ruled out?** ☐ **Yes** ☐ **No** **If no, treatment started?** ☐ **Yes** ☐ **No**

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical Information

DIAGNOSIS ☐ 696.1 Psoriasis ☐ 696.0 Psoriatic Arthritis ☐ Other:_____

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): _____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Cimzia®** *only for PsA	**Starter Dose** ☐ Starter Kit (200 mg Prefilled Syringes) ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS ☐ 3 Kits = 3 cartons of 2 x 200 mg Vials	
	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 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg Vials	_____
☐ **Enbrel®**	☐ 50mg/mL Sureclick® Autoinjector ☐ 50mg/mL Prefilled Syringe	☐ Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (72-96 hours apart) x 3 months	☐ 8	_____
		☐ Inject 50 mg SC ONCE a week	☐ 4	_____
☐ **Humira®**	☐ 40mg/0.8ml Prefilled Auto Pen ☐ 40mg/0.8ml Prefilled Syringes	☐ Starter Pack: 80 mg SC Day 1, then 40 mg one week later (Day 8), then 40 mg every other week thereafter	☐ 4	_____
		☐ Maintenance Dose: 40 mg SC every two weeks ☐ Inject 40 mg SC ONCE a week	☐ 2 ☐ 4	_____ _____
☐ **Simponi®** *Only for PsA	☐ 50mg/0.5ml SmartJect™ Autoinjector ☐ 50mg/0.5mL Prefilled Syringe	☐ Inject 50 mg SC once a month	☐ 1	_____
☐ **Stelara®**	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	☐ Initiation Dose: Inject the contents of 1 prefilled syringe SC initially Day 1	☐ 1	_____
		☐ Maintenance Dose: Inject the contents of 1 prefilled syringe SC starting Day 29 & every 12 weeks thereafter	☐ 1	_____

Patient Support

Enbrel Injection Training or Nurse Support: **Physician Signature required for Injection Training**
ENBREL *Support*™ Nurse (RN) to provide education & training for subcutaneous injection of Enbrel ☐ Nurse Training Needed

Humira Injection Training or Nurse Support: **Physician Signature required for Injection Training**
myHUMIRA Nurse (RN) visit to provide education & training for subcutaneous injection of Humira including PRN administration by the Nurse (RN) ☐ Patient's Home or Clinic Site ☐ Physician's Office ☐ No Nurse

Stelara Patient Self-Injection: Patient eligible for self-injection: ☐ Yes ☐ No

Simponi Injection Training/Nurse Support: ☐ SimponiOne RN to provide education & training for Sub-Q injection ☐ No Nurse Training

Patient Support:
I authorize SPS Specialty Pharmacy Services to enroll me in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize SPS Specialty Pharmacy Services to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, contact me occasionally for market research purposes, and provide educational information regarding therapies and disease states. I understand I may revoke this authorization at anytime in writing by sending a letter to SPS Specialty Pharmacy Services, Plaza Notre Dame #5, 75 Ave. Luis Muñoz Marín Caguas, PR 00725. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.
Patient Signature (required): _____ **Date:** _____

Prescriber Information

Date Shipment Needed:_____ Ship to: _____Patient _____Physician/Clinic
Ship to Other:_____
Physician Name (please print):_____ Contact Name:_____
Phone #:_____ Fax #: _____ NPI #: _____
Office Address: _____ City: _____ State: _____ Zip:_____
I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician's Signature:_____ Date:_____