SUPERIOR SPECIALTY PHARMACY
Transforming lives one patient at a time

# Psoriasis Enrollment

Phone: 813-960-2020
Fax: 813-549-3810
Toll Free: 877-436-2020

## Patient Information

Date: _____ Patient SSN: _____ ☐ Male ☐ Female
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State_____ Zip_____
Best Phone #: _____ Alternate Phone #: _____
DOB: _____ Caregiver: _____ Allergies: _____
**TB/PPD Test Given?** ☐ Yes ☐ No **Negative TB/PPD Test Given?** _____

## Insurance Information

**Fill out entirely OR fax copy of patient's insurance card - both sides**

Primary Insurance: _____ Secondary Insurance: _____
Insured: _____ Insured: _____
Phone #: _____ Phone #: _____
Policy #: _____ Policy #: _____
RxBIN: _____ RxPCN: _____ RxBIN: _____ RxPCN: _____

## Clinical Information

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

Does Patient have a latex allergy? ☐ Yes ☐ No Other Comments: _____
_____ % BSA (Body Surface Area) affected by Psoriasis
Patient complains of joint pain, developing PsA ☐ Yes ☐ No
Has Hepatitis B been ruled our or treatment been initiated? ☐ Yes ☐ No
If No, has treatment been initiated? ☐ Yes ☐ No

**Main contraindications for systemic use:** Alcohol use: ☐ Yes ☐ No
Childbearing age: _____ Elevated Liver Enzymes: ☐ Yes ☐ No

**Prior (FAILED) Medications:**

| | Medication | Date |
|---|---|---|
| Biologics | | |
| Methotrexate | | |
| Oral Meds | | |
| PUVA | | |
| UVB | | |
| Topicals | | |
| Other | | |

## Prescription

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Enbrel | ☐ 50mg/ml Sureclick Autoinjector<br>☐ 50mg/ml Prefilled Syringe<br>☐ _____ | ☐ **Psoriasis Induction Dose:** Inject 50 mg SC TWICE a week (72-96 hours apart) x 3 months<br>☐ Inject 50 mg SC ONCE a week<br>☐ Maintenance dose q weekly | 4-week supply | _____ |
| ☐ Humira | ☐ Prefilled Auto Pen<br>☐ Prefilled Syringes<br>☐ _____ | ☐ **Starter Pack:** 80mg Day 1, then 40mg one week later (day 8) then 40mg every other week, Dispense #4 THEN MAINTENANCE DOSE 40mg every two (2) weeks #2<br>☐ Inject 40mg SC every OTHER week<br>☐ Inject 40mg SC ONCE a week<br>☐ _____ | 4-week supply | _____ |
| ☐ Stelara™ | ☐ 45 mg Prefilled Syringes<br>☐ 90 mg Prefilled Syringes | **Starter Dose:** Request Delivery Date: _____<br>☐ 2 single-use prefilled syringes; 45 mg SC at Week 0 & Week 4<br>☐ 2 single-use prefilled syringes; 90 mg at Week 0 and Week 4<br>**Maintenance Therapy:**<br>☐ 1 single-use prefilled syringe; 45 mg SC every 12 weeks<br>☐ 1 single-use prefilled syringe; 90 mg SC every 12 weeks | 4-week supply<br>12-week supply | _____<br>_____ |

## Patient Support

**Injection Training/Humira Nurse Support**
my Humira Nurse (RN) visit to provide education and training for subcutaneous injection of HUMIRA.
☐ Patient's Home ☐ Physician's Office ☐ No nurse services required

**PATIENT SUPPORT MY HUMIRA PROGRAM:**
I authorize Superior Specialty Pharmacy 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 Superior to release and communicate to the corresponding manufacturer the minimal neccesary information about my health condition and prescription(s), to coordinate the delivery of products and services available through the patient assistance program, aggregate deindentified dose 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 any time in writing by sending a letter to Superior Specialty Pharmacy, 5416 Town N' Country Blvd., Tampa, FL 33615. I understand that I may refuse to sign this authorization and any 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 the original.

Patient Signature (required): _____ Date: _____

## Prescriber Information

Date Shipment Needed: _____ Ship to: _____ Patient _____ Physician / Clinic
Ship to Other: _____
Physician's Name (please print) _____ Contact Name: _____
Phone #: _____ Fax #: _____ NPI #: _____
Office Address: _____
Physician's Signature: _____

I authorize Superior Specialty Pharmacy, 5416 Town N' Country Blvd., Tampa, FL 33615 and its representatives to act as an agent to initiate and excute the insurance prior authorization process.