ardon

Psoriasis Enrollment Form

Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email: _____
Last Four of SS #: _____ Primary Language: _____
Height: _____ Weight: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date: _____ **Ship to:** ☐ Patient ☐ Physician ☐ Other: _____

Date of Diagnosis: **Diagnosis:** ☐ L40.0 -Psoriasis Vulgaris ☐ L40.59 Psoriatic Arthritis ☐ Other ____

Prior (FAILED) Therapies	Medication	Reason for Discontinuation	Prior Medication	Medication	Reason for Discontinuation
☐ Biologics			☐ UVB		
☐ Methotrexate			☐ Topical		
☐ Oral Meds			☐ Other		
☐ PUVA					

Current Medications: _____ **Is the patient also taking methotrexate?** ☐ Yes ☐ No

Allergies: _____ **Does the patient have a latex allergy?** ☐ Yes ☐ No

Is the patient new to therapy? ☐ Yes ☐ No

BSA affected by Psoriasis ____%

Has patient had positive TB test? ☐ Yes ☐ No If yes, date of last chest x-ray:

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Cimzia®	**Starter Dose** ☐ Starter Kit (200 mg Prefilled Syringes)	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS	0
	Maintenance Dose ☐ 200mg/ml Prefilled Syringe ☐ 200mg Vial	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks ☐ Other: ____	☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg Vials	____
☐ Enbrel®	☐ 50mg/ml Sureclick™ ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Psoriasis Induction Dose: Inject 50mg SQ TWICE a week (3-4 days apart) for 3 months, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 50mg SQ ONCE a week. ☐ Psoriatic Arthritis Dose: Inject 50mg SQ ONCE a week. ☐ Other: ____	____	____
☐ Humira®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Psoriasis Starter dose: Inject 80mg SQ day 1, 40mg Day 8, then 40mg every 14 days thereafer ☐ Inject 40mg SQ every OTHER week ☐ Inject 40mg SQ every week ☐ Other: ____	☐ 2 ☐ 4	____
☐ Simponi®	☐ 50mg/0.5ml SmartJect™ ☐ 50mg/0.5ml Syringe	☐ Inject 1 dose (50mg) Sub-Q once monthly ☐ Other: ____	☐ 1 (one)	____
☐ Stelara ®	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	☐ Initiation Dose: Inject 1 prefilled syringe Sub-Q Day 1	☐ 1 PFS	0
		☐ Maintenance Dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	☐ 1 PFS	____
☐ Cosentyx ®	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Pen	☐ Psoriasis Initiation Dose: Inject 300mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29	☐ 8 Pens/PFS	0
		☐ Psoriasis Maintenance Dose: Inject the contents of 300mg Sub-Q starting Day 29 & then every 4 weeks thereafter	☐ 2 Pens/PFS	____
		☐ Psoriatic Arthritis/Ankylosing Spondylitis Initiation Dose: Inject 150mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29	☐ 4 Pens/PFS	
		☐ Psoriatic Arthritis/Ankylosing Spondylitis Maintenance Dose: Inject the contents of 150mg Sub-Q starting Day 29 & then every 4 weeks thereafter	☐ 2 Pens/PFS	
☐ Otezla	☐ Otezla Starter Pack ☐ Otezla 30mg Tablet	☐ Initiation Dose: Take as directed per package instructions	☐ 1 Starter Kit (55 tablets)	0
		☐ Maintenance Dose: Take 1 tablet by mouth twice daily	☐ 60 Tablets	____
☐ Remicade®	☐ Remicade 100mg vial	☐ Induction: Infuse _____mg IV at weeks 0, 2, and 6 ☐ Maintenance: Infuse _____mg IV at every 8 weeks	☐ _____ # Vial(s)	____

X _____ X _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

PHYSICIAN SIGNATURE REQUIRED

Date Needed: _____ Medication Start Date: _____