

Request Form For Self Injectable Biological For Treating Psoriasis, Psoriatic Arthritis or Ankylosing Spondylitis

(i.e. Enbrel® or Humira®)

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041** or urgent requests to **866-533-5497**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-369-6037**. *Form must be completed for processing.*



Patient Name: _____ Plan ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Weight: _____ lbs = _____ Kg Birth Date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____

Drug to be administered from (on): _____ to _____
 Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

Has the member been evaluated for active or latent TB infection? YES NO Date of PPD (tuberculin skin test): _____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

Drug Name: _____ Dose: _____ Sig: _____

Deliver to Patient's Home Deliver to Physician's Office Pick-up at Local Pharmacy (Name/Phone#): _____

Please identify the therapies attempted by completing the medication chart below indicating the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, treatment failure and/or any other medical reasons). Please attach any needed applicable documentation.

<input checked="" type="checkbox"/>	Drug	Dose/Sig.	Start Date	End Date	Comments
<input type="checkbox"/>	Topical Therapies: Please indicate their name(s):				
<input type="checkbox"/>	Methotrexate (MTX)				
<input type="checkbox"/>	Cyclosporine				
<input type="checkbox"/>	Sulfasalazine				
<input type="checkbox"/>	Phototherapy UVA/UVB therapy				
<input type="checkbox"/>	Etanercept (Enbrel®)*				
<input type="checkbox"/>	Adalimumab (Humira®)*				
<input type="checkbox"/>	Other ()				

Additional comments: _____