

PSORIATIC ARTHRITIS

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance		
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)		
Group/Policy #		Group/Policy #		
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)		
Employer		Medicaid #		

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name		
Hospital/Clinic		Office Contact		
Street Address				
City		State	ZIP	
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address	
Prescriber's License #		DEA #	NPI #	
UPIN#		Medicaid License #		

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)
 696.0 Psoriatic Arthritis Date of Diagnosis: / /
 Other ____ (Please Specify)
 TB Test Performed? Yes No If Yes, Results: _____
 Does Patient Have Active/Chronic Infection? Yes No
 Has Patient Been Diagnosed with Lymphoma? Yes No
 Has Patient Been Diagnosed with Heart Failure? Yes No
 Previous Treatment: (Please Specify)

Systemic ____ (Please Specify)
 Other ____ (Please Specify)
 Systemic Treatments Contradicted. Reasons _____
 Comments: _____

INJECTION TRAINING:

Injection Training Will Be/Has Been Conducted by the Physician's Office?
 Yes No Date: / /
 First Dose of Medication Will Be/Has Been Administered at Physician's Office?
 Yes No Date: / /
 Caremark to Refer/Coordinate Injection Training?
 Yes No

Rx

Patient Weight ____ kg. **OR** ____ lbs.
Drug Allergies _____
 NKDA
 Enbrel® 50 mg SureClick Autoinjector 50 mg Prefilled Syringe 25 mg Vial
 Quantity: _____
 SIG: 50 mg SQ QW or 25 mg SQ BIW Other: _____
 Humira® 40 mg Prefilled Pen 40 mg Prefilled Syringe
 Quantity: _____
 SIG: 40 mg SQ Every Other Week Other: _____
 Remicade® 100 mg Vial
 Quantity: _____
 SIG: Infuse 5 mg/kg in 250 ml of 0.9% NaCl as Directed
 Other: _____ Freq: _____
 Home Health Nurse to Administer
 Other _____

Ancillary Supplies and Kits Provided As Needed for Administration.

Other Prescriber's Notes:

Refill ____ Times
 Dispense As Written Substitution Allowed
Prescriber's Signature _____ **Date** _____

PHYSICIAN SPECIALTY: Dermatologist Rheumatologist
 Other (Specify) _____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!