

Request Form for Self Injectable Biological for Treating Psoriasis, Psoriatic Arthritis or Ankylosing Spondylitis (e.g. Enbrel® or Humira®)

Fax non-urgent requests to PerformRx Pharmacy Services at 877-693-8280 or urgent requests to 877-693-8476.

Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

To speak to a representative, call 800-578-0898. Form must be completed for processing



Patient Name: _____ Patient 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: _____ LTC member Yes No, Date Admitted _____

Drug to be administered from (on): _____ to _____ Or was administered on: _____ to be replaced to physician's office.

Has the member been evaluated for active of 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 ()				

*These medications require prior authorization

Additional comments: _____

