MAXOR SPECIALTY

RA/Dermatology Enrollment Form
Patient Referral/Medication Request Form

Phone: 806-324-5447 • Toll Free Phone 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

Patient Information

Patient Name _____

Date of Birth _____ Male ☐ Female ☐

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone Home _____

Work _____ Cell _____

Social Security # _____

Allergies _____ NKA ☐

Weight _____ kg ☐ lb ☐

Emergency Contact Name _____

Phone _____

Please attach copy of insurance information or copy of insurance cards (both sides).

Shipping Information

☐ Patient's Home ☐ Physician's Office

☐ Other _____

Date Medication Needed _____

Physician Information

Physician Name _____

Office Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Physician Signature _____

Date _____

☐ Dispense as written ☐ Generic substitution permitted

Diagnosis/Medical Information

ICD9 Code:

☐ 696.0 Psoriatic Arthropathy ☐ 696.1 Other Psoriasis

☐ Other (include code) _____

TB Test:

TB test ☐ Yes ☐ No

Results: _____

Severity: ☐ Moderate ☐ Moderate to Severe ☐ Severe ☐ BSA _____%

Type: ☐ Plaque ☐ Other (please specify): _____

Prior (FAILED) Medications: ☐ Biologics ☐ Methotrexate ☐ Oral Meds ☐ PUVA ☐ UVB ☐ Topicals ☐ Other: _____

Injection Training/Home Health

☐ Specialty Pharmacy to coordinate injection training

☐ Home health nurse to visit as necessary. ☐ Injection training is not necessary.

Additional Comments: _____

Prescription Information

Amevive® (alefacept)

☐ Initial Treatment ☐ Retreatment**

☐ 7.5mg IV once wkly for 12 weeks

☐ 15mg IM once wkly for 12 weeks

☐ Other: _____

**Patients are only eligible for Retreatment if CD4+ lymphocyte counts are within normal limits and a minimum of a 12 week interval has passed since previous treatment course.

Enbrel® (etanersept)

☐ 25mg/0.5ml PFS ☐ 25mg vial

☐ 50mg/ml PFS ☐ 50mg/ml SURECLICK

☐ 50mg SC twice wkly (72-96 hours apart) for first 3 months

☐ 50mg SC once wkly after first 3 months

☐ 25mg SC twice wkly (72-96 hours apart)

☐ Other: _____

Humira® (adalimumab)

Initial Therapy

☐ 40mg/0.8ml Psoriasis Starter Kit (4 pens/box)
Two 40mg pens (80mg) followed by one 40mg pen every other week starting one week after the initial dose. Dispense #1 Kit; no refills

Maintenance Therapy

☐ 40mg/0.8ml, PEN (2 pens/box)

☐ 40mg/0.8ml, PFS (2 pfs/box)

Inject 40mg SC every other week

☐ Other: _____

Remicade® (infliximab)

Initial Therapy

☐ 5mg/kg IV given at 0, 2, & 6 weeks

Maintenance Therapy

☐ 5mg/kg IV every 8 weeks

☐ Other: _____

Stelara™ (ustekinumab)

Initial Therapy

☐ ≤100kg (220lbs) 45mg SC; repeat dose in 4 weeks

☐ >100kg (220lbs) 90mg SC; repeat dose in 4 weeks

Maintenance Therapy

☐ ≤100kg (220lbs) 45mg Q 12 wks starting at 16 wks

☐ >100kg (220lbs) 90mg Q 12 wks starting at 16 wks

Dispense:

☐ 1 month supply ☐ 3 months supply

Refill _____ times

Need Supplies: **Please specify** _____

Ancillary supplies/kits provided as needed for administration.