Psoriasis Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
Member ID#: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:		Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ COSENTYX 150mg PFS ☐ COSENTYX 150mg PEN	☐ **Loading dose:** mg SQ at week 0,1,2 3 and 4 followed by, ☐ **Maintenance dose:** mg SQ every 4 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ ENBREL 50mg ☐ PEN ☐ PFS ☐ MINI CARTRIDGE ☐ ENBREL 25mg ☐ PFS ☐ VIALS	☐ **Loading dose:** 50mg SQ twice a week for 3 months then, ☐ **Maintenance dose:** 50mg SQ every week ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ HUMIRA **Initial dose:** ☐ HUMIRA PEN PSORIASIS STARTER KIT ☐ HUMIRA 40mg/0.4ml PFS ☐ HUMIRA 40mg/0.8ml PFS ☐ Other: _____ ☐ HUMIRA **Maintenance dose:** ☐ HUMIRA 40mg/0.4ml ☐PEN ☐ PFS ☐ HUMIRA 40mg/0.8ml ☐PEN ☐ PFS ☐ HUMIRA 20mg/0.2ml PFS ☐ HUMIRA 20mg/0.4ml PFS ☐ HUMIRA 10mg/0.1ml PFS ☐ HUMIRA 10mg/0.2ml PFS ☐ Other: _____	☐ **Loading dose:** ☐ 80mg SQ on day 1, then 40mg every other week starting 1 week after initial dose ☐ Other: ☐ **Maintenance dose:** ☐ 40mg SQ every other week ☐ 40mg SQ every week ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ INFLECTRA 100mg VIALS ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ **Loading dose:** Infuse IV at week 0, week 2, and week 6 ☐ **Maintenance dose:** Infuse IV every _____ weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 dose ☐ Other:	
☐ METHOTREXATE 25mg/1mL INJECTION ☐ SDV ***OR*** ☐ MDV	***DOSE:*** _____mg ***ROUTE:*** ☐ SQ ☐ IM ☐ Inject once every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

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A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
Member ID#: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐P.A.			
Address:	City:	State:	ZIP:	
Phone: Fax:	DEA #:	NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ OTEZLA TITRATION STARTER PACK ☐ OTEZLA 30mg Tablets	☐ **Starter kit**: Take as per package instructions. ☐ 1 tablet by mouth twice daily ☐ Other:	☐ Starter kit ***then:*** ☐ 1 month ☐ 3 months	
☐ OTREXUP AUTOINJECTOR ☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg	☐ Inject SQ once every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ RASUVO AUTOINJECTOR ☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 27.5mg ☐ 30mg	☐ Inject SQ once every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ REMICADE 100mg VIALS ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ **Loading dose:** Infuse IV at week 0, week 2, and week 6 ☐ **Maintenance dose:** Infuse IV every _____ weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 dose ☐ Other:	
☐ SILIQ 210mg PFS	☐ **Loading dose**: Inject SQ at week 0, week 1 and week 2, and then every 2 weeks ☐ **Maintenance dose:** Inject SQ every 2 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ STELARA 45mg PFS ☐ STELARA 45mg VIAL ☐ STELARA 90mg PFS	☐ **Loading dose**: Inject _____mg SQ at week 0, week 4, and then every 12 weeks ☐ **Maintenance dose:** Inject _____mg SQ every 12 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 dose ☐ Other:	
☐ Other:			

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

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Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.

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Member ID #: _____	If yes, Carrier Name: _____
Group #: _____	Member ID#: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

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Address:	City:	State:	ZIP:	
Phone: Fax:	DEA #:	NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ TALTZ 80mg ☐ PEN ☐ PFS	☐ **Loading dose:** Inject 160mg SQ at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10 and 12, then 80mg every 4 weeks ☐ **Maintenance dose:** Inject 80mg SQ every 4 weeks. ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ TREMFYA 100mg PFS	☐ **Loading dose**: Inject SQ at week 0, week 4, and then every 8 weeks ☐ **Maintenance dose:** Inject SQ every 8 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 dose ☐ Other:	
☐ Other:			

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

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