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

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

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: _____

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.

☑	Drug	Dose/Sig.	Start Date	End Date	Comments
☐	Topical Therapies: Please indicate their name(s):				
☐	Methotrexate (MTX)				
☐	Cyclosporine				
☐	Sulfasalazine				
☐	Phototherapy UVA/UVB therapy				
☐	Etanercept (Enbrel®)*				
☐	Adalimumab (Humira®)*				
☐	Other ( )				

*These medications require prior authorization

Additional comments:

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