

Patient Information

Patient Name: _____
 Date of Birth: _____ Sex: _____ SS# _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Patient: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
 Physician Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____
 Date Shipment Needed: _____
 Ship to: ☐ Patient ☐ Prescriber ☐ Infusion Clinic
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee the recipient should immediately notify the sender at the address and telephone number set forth herein and obtains instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee by express authority of the sender to the named addressee. Orchard Pharmaceutical Services, Inc. 6-2013

Clinical Information and Prescription

Diagnosis: ___ 696.1 Psoriasis ___ 696.0 Psoriatic Arthritis
 ___ Other: _____
 Date of Diagnosis or Years with Disease: _____
 Patients Allergies: _____
 Latex allergy: ___ Yes ___ No
 Patient Weight: _____ Patient Height: _____
 BSA (Body Surface Area) affected by Psoriasis: _____ %
 Has the patient had a NEGATIVE tuberculin skin test: ___ Yes ___ No
 Has Hepatitis B been ruled out? ___ Yes ___ No
 Prior Failed Medications and Date _____
 Expected First Dose Date: _____ Injection Instruction needed: ___ Yes ___ No

☐ **Enbrel® (etanercept)**
 Dose: ___ Psoriasis induction dose: 50 mg SC twice a week (3-4 days apart) x 3 months
 ___ Inject 50mg SC once a week
 ___ 50mg prefilled syringe ___ 50mg SureClick

☐ **Humira® (adalimumab)**
 Dose: ___ 80 mg SC Day 1, then 40mg Day 8, then 40mg every other week thereafter
 (Psoriasis Starter Pack)
 ___ 40mg every two weeks (maintenance dose)
 ___ 40mg/0.8ml PFS ___ 40 mg/0.8ml Pens

☐ **Remicade® (infliximab)** infuse NS 250ml over 2 hours as directed
 Dose: ___ (New start) 5 mg/kg @ 0, 2, 6 weeks
 ___ 5 mg/kg every 8 week ___ Other Remicade dosing: _____

☐ **Simponi® (golimumab)** inject 50mg subcutaneously once per month (**only for PsA**)
 Dose: ___ 50mg/0.5ml SmartJect™ ___ 50mg/0.5ml prefilled syringe

☐ **Stelara® (ustekinumab)**
 Dose (patients <100kg): ___ 45mg SC at week 0, week 4 followed by a maintenance dose of 45 mg SC every 12 weeks
 Dose (patients > 100kg): ___ 90mg SC at week 0, week 4 followed by maintenance dose of 90 mg SC every 12 week

Quantity Prescribed: ☐ QS 30 days ☐ QS 90 days ☐ Other: _____
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____

X
Physician Signature (no stamps)
Date