Gigi Specialty Pharmacy

Psoriasis/Psoriatic Arthritis Enrollment Form

A Dose Of Kindness With Every Perscription.

Ship to: ☐ Patient ☐ Office ☐ Other: Date: Needs by Date:

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name _____

State License # _____ UPIN _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION

Diagnosis

Please include diagnosis name and ICD-10

☐ 696.1 Psoriasis-L40.0-Psoriasis

☐ 696.0 Psoriatic Arthritis-L40.59-Other Psoriasis Arthropathy

☐ Other: ICD-10 _____ Diagnosis _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication		Dose/Strength	Directions	Quantity	Refills
☐ Enbrel (Amgen)	☐ Enroll in Enliven*				
☐ Humira (Abbott)	☐ Enroll in myHUMIRA*				
☐ Remicade (Centocor)	☐ Enroll in AccessOne*				
☐ Simponi (Janssen Biotech)	☐ Enroll in SimponiOne*				
☐ Stelara (Janssen Biotech)	☐ Enroll in Stelara Support*				

***Patient Authorization:** I authorize NLSP to enroll me in the manufacturer's patient support program checked above to receive services such as, but not limited to, injection training. I further authorize NLSP to share minimum necessary information about my health condition and treatment to the manufacturer's program to provide educational materials on Psoriasis/Psoriatic Arthritis, delivery of products and services offered by the program, and aggregated de-identified data for market analysis. I understand that I may revoke this authorization at any time by contacting NLSP also understand that I may refuse to sign this authorization and I will still be eligible for treatment by NLSP

Patient's Signature _____ Date _____

Prescriber's Signature _____ _____

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*