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

AmeriHealth Caritas Pennsylvania

Fax to Pharmacy Services at **888-981-5202**, or call **866-610-2774** to speak to a representative. ***Form must be completed for processing***.

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: _____ Date: _____

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:

☐Member's Home ☐Physician's Office ☐Member's Preferred Pharmacy (Name/Phone#):_____

☐ I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication.

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:_____