

**Request Form for Self Injectable Biological for Treating Psoriasis, Psoriatic Arthritis or Ankylosing Spondylitis**

**(e.g. Enbrel® or Humira®)**

Fax to Keystone Mercy Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. *Form must be completed for processing.*



*A Program of Keystone First and Mercy Health Plan*

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.*

<input checked="" type="checkbox"/>	Drug	Dose/Sig.	Start Date	End Date	Comments
<input type="checkbox"/>	Topical Therapies: Please indicate their name(s):				
<input type="checkbox"/>	Methotrexate (MTX)				
<input type="checkbox"/>	Cyclosporine				
<input type="checkbox"/>	Sulfasalazine				
<input type="checkbox"/>	Phototherapy UVA/UVB therapy				
<input type="checkbox"/>	Etanercept (Enbrel®)*				
<input type="checkbox"/>	Adalimumab (Humira®)*				
<input type="checkbox"/>	Other ( )				

\*These medications require prior authorization

Additional comments: