



Enbrel® Therapy Psoriasis/Psoriatic Arthritis Fax to 866-406-4215

MEDICA®

Customer Service: 866-406-4209

Patient Information Please type or print clearly.	Name		
	Address		
	City	State	ZIP Code
	DOB		
	Home Phone w/area code	Work Phone w/area code	
Insurance Information <input type="checkbox"/> Major Medical <input type="checkbox"/> Rx Benefit Please attach a copy of card(s) if possible.	Primary Insurer		
	Cardholder		
	DOB		
	Cardholder ID #	Group #	
	RxCARD ID #	RxBIN #	RxGroup #
	Phone w/area code	Fax w/area code	
Medical Assessment	Diagnosis <input type="checkbox"/> 696.1 Psoriasis <input type="checkbox"/> 696.0 Psoriatic Arthritis		
	Allergies		
Prescription To be valid, prescription must be faxed from a prescriber's office. Facsimile not valid for C-II prescriptions.	Enbrel®		
	Dispense:		
	<input type="checkbox"/> Enbrel 25 mg Kit (4 vials)		
	<input type="checkbox"/> Enbrel 50 mg Prefilled Kit (4 syringes)		
	<input type="checkbox"/> Enbrel 50 mg SureClick™ Autoinjector Kit (4 syringes)		
	Directions:		
	<input type="checkbox"/> Two 25 mg (50 mg) SC injections once a week <input type="checkbox"/> Two 25 mg (50 mg) SC injections twice a week		
	<input type="checkbox"/> 25 mg SC injection twice a week <input type="checkbox"/> 50 mg SC injection once a week		
	<input type="checkbox"/> 50 mg SC injection twice a week		
	<input type="checkbox"/> _____		
Days Supply _____			
Refills X _____			
Prescriber Certification <input type="checkbox"/> Please acknowledge receipt of this fax.	I certify that the prescribed therapy is medically necessary and that the information above is accurate to the best of my knowledge.		
	Prescriber Signature Required	Date	
	Print Prescriber Name		
	Form Faxed By	UPIN	
	Address	DEA #	
	City	State	ZIP Code
	Phone w/area code	Fax w/area code	

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