



214 E. Fulton Grand Rapids, MI 49503  
 Phone: 616.301.8200  
**FAX This Form To: 616.301.8201**

**HUMIRA™**  
**ENROLLMENT**  
**Psoriatic Arthritis**



**Patient Information**

Date: \_\_\_\_\_ Patient SS# \_\_\_\_\_  Male  Female  
 Patients first name \_\_\_\_\_ Patient's last name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Weight \_\_\_\_\_ kgs or lbs (circle one) Recorded Date \_\_\_\_\_  
 Caregiver \_\_\_\_\_ Allergies \_\_\_\_\_

**Insurance Information (fill out entirely OR fax copy of patient's insurance card - both sides)**

Employer \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
 Insured \_\_\_\_\_ Insured \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone \_\_\_\_\_  
 Policy# \_\_\_\_\_ Policy# \_\_\_\_\_

**Treatment**

**SIG/Directions**

Humira Strength: 40mg Pre-filled syringe 40mg (one syringe) every two (2) weeks  
 Other \_\_\_\_\_

**REFILLS**

Quantity refills \_\_\_\_\_  
 x \_\_\_\_\_ Months

**DIAGNOSIS OF Psoriatic arthritis (696.0)**

**PATIENT HAS A NEGATIVE TB TEST RESULT** Date of Test \_\_\_\_\_

Treatment failure with one or more DMARD.

Ridaura Trial Dates \_\_\_\_\_  Azathioprine Trial dates \_\_\_\_\_  
 Plaquenil Trial Dates \_\_\_\_\_  Methotrexate Trial Dates \_\_\_\_\_  
 Neoral Trial Dates \_\_\_\_\_  Sulfasalazine Trial Dates \_\_\_\_\_  
 Penicillamine Trial Dates \_\_\_\_\_

**Supportive / Additional Treatment**

Dosage \_\_\_\_\_  
 Directions \_\_\_\_\_  
 Quantity \_\_\_\_\_ Refills x \_\_\_\_\_ Months

Today's Date \_\_\_\_\_ Date Shipment Needed \_\_\_\_\_ Ship to: \_\_\_Patient \_\_\_Physician/Clinic  
 Ship to Other \_\_\_\_\_  
 Physician's name: (please print) \_\_\_\_\_ Physician's Ph#: \_\_\_\_\_  
 Physician's signature \_\_\_\_\_ Contact person: \_\_\_\_\_ DEA# \_\_\_\_\_  
 Office Address: \_\_\_\_\_ Physician's Fax#: \_\_\_\_\_

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