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Supervising/Collaborative Physician Information (per state requirements)

Dermatology Enrollment Form

Page 1 of 8 (A-B)

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596 This form is not a valid prescription in Arizona or Virginia **Specialty Pharmacy Enrollment Form PATIENT INFORMATION** PRESCRIBER INFORMATION Please complete the following or send patient demographic sheet DEA Patient Name NPI Address 2 Group/Hospital City, State, Zip Address Home Phone _ City, State, ZIP Alternate Phone Gender_ DOB Last Four of SS# Phone Fax Contact Person Language Preference: English Spanish Other INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides) Prior Authorization Reference number: MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed) Diagnosis - Please include diagnosis name with ICD-10 code Reauthorization Restart Additional Information Therapy: New L20 Atopic dermatitis L40.1 Generalized pustular psoriasis Weight _ __ kg/lbs Height cm/in L28.1 Prurigo nodularis L40.3 Pustulosis palmaris et plantaris Allergies _ L40.0 Psoriasis vulgaris L40.54 Psoriatic juvenile arthropathy Lab Data L40.59 Other psoriatic arthropathy L40.2 Acrodermatitis continua Prior Therapies _ L40.4 Guttate psoriasis L73.2 Hidradenitis suppurativa L40.8 Other psoriasis _ Concomitant Medications ____ Other Diagnosis: ICD-10 Code ______ Description _ Date of Diagnosis Additional Comments Yes Has a TB test been performed? No Does the patient have an active infection? Yes ПNо Injection Training Required: Yes No **Review Date** PRESCRIPTION INFORMATION Medication Dose & Directions Qtv/Refills Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week 20mg/0.4mL prefilled syringe 40mg/0.8mL prefilled syringe Abrilada™ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week Quantity: Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 (adalimumah-Refills: afzb) 40mg/0.8mL pen HS maintenance: 40mg SQ every week starting on Day 29 Alternate HS maintenance: 80mg QV every other week starting on Day 29 Induction Dose: Inject SC four 150mg injections on Day 1, followed by two 150mg injections every other week. ___ Adbry Quantity:___ Maintenance Dose: (tralokinumab-150mg/mL prefilled syringe Inject SC two 150mg injections every other week. Refills: __ Idrm) Inject SC two 150mg injections every four weeks. Consideration if body weight is below 100 kg, and completed 16 weeks of treatment. Psoriasis Induction Dose: Inject 80mg SC on day 1, followed by 40mg SC on day 8, then 40mg 40mg/0.8 mL Prefilled Syringe (citrate-free) Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 Amjevita™ Quantity: 40mg/0.8 mL Prefilled SureClick® autoinjector (adalimumab-HS maintenance: 40mg SQ every week starting on Day 29 (citrate-free) Refills: atto) Alternate HS maintenance: 80mg QV every other week starting on Day 29 Other Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. Other Induction Dose: Infuse 5mg/kg (Dose = ____mg) IV at week 0, week 2, week 6 and every Quantity:_ 8 weeks thereafter (0 refills). Avsola⁶ 100mg Vial # of 100mg vial Maintenance Dose: Infuse 5mg/kg (Dose = ____mg) IV every 8 weeks. (infliximab-axxq) Refills: _ Induction: inject 320mg (2 x 160mg injections) subcutaneously at weeks 0, 4, 8, 12, and 16 Bimzelx® Quantity: 160mg/1mL autoinjector (bimekizumab-Maintenance: inject 320mg (2 x 160mg injections) subcutaneously every 8 weeks 160mg/1mL prefilled syringe Refills: bkzx) *Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Ship to: Patient Office Other Needs by date:_ **Substitution Permitted** Dispense as Written Prescriber's Prescriber's Date Date Signature Signature

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Specialty Pharmacy Enrollment Form

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| PATIENT INFO | DRMATION | | PRESCRIBER INFORMA | ATION | |
|---|---|--|--|---|--|
| Please complete the following or send patient demographic sheet | | | Prescriber's Name | | |
| Patient Name | | | DEA | | |
| Address | | | NPI | | |
| Address 2 | | | ., . | | |
| City, State, Zip | | | - | | |
| Home Phone Alternate Phone DOB Last Four of SS# Gender | | | Fox | | |
| Language Preference: English Spanish Other | | | Phone Fax Contact Person Phone | | |
| | NFORMATION (Must fax a copy of patie | | | | |
| | Reference number: | ent sinsurance card in | cidding both sides) | | |
| | ORMATION (Section must be complete | ad to process prescript | tion) (Attach concrete sh | act if pandad) | |
| | se include diagnosis name with ICD-10 code | ed to process prescript | Additional Information | Therapy: New Reauthoriz | ation Restart |
| L40.0 Psoriasi | s vulgaris L40.1 Generalized | pustular psoriasis | Weight | kg/lbs Height | cm/in |
| L40.2 Acroder | matitis continua 🔲 L40.3 Pustulosis p | almaris et plantaris | | | |
| L40.4 Guttate | | | · · | | |
| _ | | | | | |
| L40.59 Other | psoriatic arthropathy | suppurativa | Prior Therapies | | |
| L40.8 Other p | soriasis | | Concomitant Medications | | |
| Other Diagno | sis: ICD-10 Code Description | | | | |
| Date of Diagnosi | s | | Additional Comments | | |
| Has a TB test bee | en performed? | | | | |
| Does the patient | have an active infection? Yes No | | | | |
| Start Date | Review Date | | Injection Training Required | d: UYes No | |
| PRESCRIPTIO | N INFORMATION | | | | |
| Medication | Strength | | Dose & Directions | | Qty/Refills |
| ☐ Cibinqo™ (abrocitinib) | 50mg tablet 100mg tablet 200mg tablet | Take 100mg PO once da | = | | Quantity: |
| Cimzia° (certolizumab pegol) | Cimzia Starter Kit (6 prefilled syringes) | Loading Dose: Inject 40 | 00mg SC (2 prefilled syringes) init | ially and at weeks 2 and 4. | Quantity: 1 Kit Refills: 0 |
| Cimzia* (certolizumab pegol) | 200mg/1 mL Prefilled Syringe | 200mg SC every other v Psoriatic Arthritis Maintena 200mg SC every other v | f 200mg each) every other week. week. ance <u>Dose:</u> week. f 200mg each) every 4 weeks. | | Quantity: Refills: |
| Cosentyx* (secukinumab) | Sensoready* pen 150mg/mL injection Prefilled syringe 150mg/mL injection UnoReady pen 300mg/2mL injection | Loading Dose: Inject 300mg SC at weeks 0, 1, 2, 3 and 4 (0 refills). Maintenance Dose: Inject 300mg SC every 4 weeks. Psoriatic Arthritis Loading Dose: (if needed): 150mg SC at weeks 0,1,2,3, and 4 (0 refills). Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. Other: | | Quantity: Refills: | |
| Cyltezo* (adalimumab- adbm) | 40mg/0.8mL Pen Psoriasis Starter Pack (4 pens) 40mg/0.8mL Pen Hidradenitis Suppurativa Starter Pack (6 pens) 40mg/0.8mL Pen 40mg/0.8mL prefilled syringe | Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 HS maintenance: 40mg SQ every week starting on Day 29 Alternate HS maintenance: 80mg QV every other week starting on Day 29 | | Quantity: Refills: | |
| for our shared patient, and other patient data coverage of the product Ship to: Patie | ion: I authorize this pharmacy and its representatives to act as n and to sign any necessary forms, where permitted by law and be that support the prior authorization. In the event that this pharr it to another pharmacy of the patient's choice or in the patient's ent Office Other Dispense as Written | nefit plan sponsor, on my behalf as r nacy determines that it is unable to insurer's provider network. | ny authorized agent, including any requ fulfill this prescription, I further authori | ired prior authorization forms and the receipt and size this pharmacy to forward this information and any Needs by date: Substitution Permitted | bmission of patient lab values related materials related to |
| | | | | • | |
| I Supervising/Co | ollaborative Physician Information (per state requir | rements) | | | |

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| PATIENT INFO | DRMATION | | PRESCRIBER INFORM | ATION | |
|--|--|--|--|--|---|
| Please complete the following or send patient demographic sheet | | | Prescriber's Name | | |
| Patient Name | | | DEA | | |
| Address | | | NPI | | |
| Address 2 | | | Group/Hospital | | |
| City, State, Zip | | | | | |
| Home PhoneAlternate Phone | | | | | |
| DOB Last Four of SS# Gender Language Preference: English Spanish Other | | | Phone | | |
| | | | | | |
| | NFORMATION (Must fax a copy of pation | ent's insurance card in | cluding both sides) | | |
| | Reference number: | | | | |
| | ORMATION (Section must be complete | ed to process prescript | | | |
| Diagnosis – Plea | ase include diagnosis name with ICD-10 code | | Additional Information | Therapy: New Reauthoriz | ation Restart |
| L20 Atopic de | ermatitis L40.1 Generalized | nustular psoriasis | Weight | kg/lbs Height | cm/in |
| L40.0 Psoriasi | <u>=</u> | | - | | • |
| _ | - | · | Allergies | | |
| | | | Lab Data | | |
| L40.4 Guttate | · — | suppurativa | Prior Therapies | | |
| _ | psoriatic arthropathy | | Concomitant Modication | S | |
| L40.8 Other p | soriasis | | Concomitant Medications | | |
| Other Diagno | sis: ICD-10 Code Description | | | | |
| Date of Diagnosi | is | | Additional Comments | | |
| Has a TB test bee | en performed? | | | | |
| Does the patient | t have an active infection? Yes No | | | | |
| Start Date | Review Date | | Injection Training Require | ed: Yes No | |
| PRESCRIPTIO | N INFORMATION | | | | |
| Medication | Strength | | Dose & Direction | s | Qty/Refills |
| Dupixent* (dupilumab) | 300mg/2ml Prefilled Pen 300mg/2mL Prefilled Syringe 200mg/1.14mL Prefilled Syringe | Adults with Atopic Dermati 600mg (two 300mg inje Pediatric Patients with Ato Body Weight 15 to less than 30 kg 30 to less than 60 kg | ections) followed by 300mg Q2V | Subsequent Doses s) 300mg Q4W s) 200mg Q2W | Quantity: Refills: |
| ☐Enbrel* (etanercept) | □ 50mg/mL Sureclick™ Autoinjector □ 50mg/mL Prefilled Syringe □ 50mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). Avella/Briova does not order the autoinjector. □ 25mg/0.5 mL Prefilled Syringe □ 25mg/0.5ml single-dose vial | Psoriasis Induction Dose then maintenance dosir Psoriasis Maintenance D | e; Inject 50mg SC TWICE a weeking (8 pens, 2 refills). 20se; Inject 50mg SC ONCE a weik. Inject 50mg SC ONCE a week. | (3 to 4 days apart) for 3 months, | Quantity: Refills: |
| ☐ Hadlima™ (adalimumab- bwwd) | 40mg/0.4ml prefilled syringe 40mg/0.8ml prefilled syringe 40mg/0.4ml PushTouch auto-injector 40mg/0.8ml PushTouch auto-injector | Psoriasis/Psoriatic Arthr Hidradenitis suppurative HS maintenance: 40mg | ritis Maintenance: Inject 40mg S | Q on Day 1, then 80mg SQ on Day 15 | Quantity: Refills: |
| ∏Hulio* (adalimumab- fkjp) | 20mg/0.4mL prefilled syringe 40mg/0.8mL prefilled syringe 40mg/0.8mL pen | Psoriasis/Psoriatic Arthr Hidradenitis suppurative HS maintenance: 40mg | ritis Maintenance: Inject 40mg S | Q on Day 1, then 80mg SQ on Day 15 | Quantity: Refills: |
| for our shared patient, and other patient data coverage of the produc | ion: I authorize this pharmacy and its representatives to act as rand to sign any necessary forms, where permitted by law and be that support the prior authorization. In the event that this pharact to another pharmacy of the patient's choice or in the patient's contact Office Other | nefit plan sponsor, on my behalf as r macy determines that it is unable to s insurer's provider network. | my authorized agent, including any rec fulfill this prescription, I further autho | uired prior authorization forms and the receipt and su rize this pharmacy to forward this information and any | ubmission of patient lab values y related materials related to |
| | Dispense as Written | | | Substitution Permitted | |
| Prescriber's | · | | Prescriber's | | |
| _ | | Date | | | Date |
| Electronic or digital s | signatures not accepted. | | Electronic or digital signatures not a | ccepted. | |
| 1 | ollaborative Physician Information (per state requi | | | | |

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| | 9 - | ease detach before submitting | | | |
|--|---|---|---|---|--|
| PATIENT INFORMATION | | | PRESCRIBER INFORMATION | | |
| Please complete | the following or send patient demographic s | heet | Prescriber's Name | | |
| Patient Name | | | DEA | | |
| Address | | | NPI | | |
| | | | Address_ | | |
| | | | City, State, ZIP | | |
| DOB Last Four of SS# Gender | | PhoneFax | | | |
| Language Preference: English Spanish Other | | Contact PersonPhone | | | |
| INSURANCE I | NFORMATION (Must fax a copy of pation | ent's insurance card in | cluding both sides) | | |
| Prior Authorization | Reference number: | | | | |
| MEDICAL INF | ORMATION (Section must be complete | ed to process prescript | tion) (Attach separate sheet if needed) | | |
| Diagnosis – Plea | se include diagnosis name with ICD-10 code | | Additional Information Therapy: New Reauthoriza | ation Restart | |
| □ I 40 0 Psoriasi | s vulgaris | pustular psoriasis | Mainta Indiana | /:- | |
| L40.0 Psoriasis vulgaris L40.1 Generalized pustular psoriasis L40.2 Acrodermatitis continua L40.3 Pustulosis palmaris et plantaris | | | Weightkg/lbs Height | | |
| L40.4 Guttate | | · · | Allergies | | |
| _ | psoriatic arthropathy | | Lab Data | | |
| | soriasis | | Prior Therapies | | |
| | sis: ICD-10 Code | _ | Concomitant Medications | | |
| | | | | | |
| | Description | | | | |
| Date of Diagnosi | s | | Additional Comments | | |
| Has a TB test bee | • = = | | | | |
| Does the patient | have an active infection? Yes No | | Injection Training Required: Yes No | | |
| Start Date | Review Date | | Injection Hailing Required. Tes Tes | | |
| PRESCRIPTIO | N INFORMATION | | | | |
| Medication | Strength | | Dose & Directions | Qty/Refills | |
| ☐ Humira® (adalimumab) | Psoriasis 80mg/0.8 mL and 40mg/0.4 mL Starter Package Citrate Free | Psoriasis Induction Dos every other week. | se: Inject 80mg SC on day 1, followed by 40mg SC on day 8, then 40mg | Quantity: 1 Package Refills: 0 | |
| ∏Humira° (adalimumab) | Hidradenitis Suppurativa 80mg/0.8 mL Starter Package Citrate Free | later (Day 15), then 40m Hidradenitis Suppurativ | va Induction Dose: Inject 160mg SC on Day 1, followed by 80mg two weeks ng every week starting on Day 29. va Induction Dose: Inject 160mg SC on Day 1, followed by 80mg two weeks ng every other week starting on Day 29. | Quantity: 1 Package Refills: 0 | |
| Humira° (adalimumab) | 40mg/0.4 mL Pen Citrate Free 40mg/0.4 mL Prefilled Syringe Citrate Free 80mg/0.8 mL Pen Citrate Free | Hidradenitis Suppurativ | ritis Maintenance Dose: Inject 40mg SC every other week. | | |
| | Other: | Hidradenitis Suppurativ Other: | <u>va Maintenance Dose:</u> Inject 40mg SC every week. <u>va Maintenance Dose:</u> Inject 80mg SC every other week | Quantity: | |
| ☐ Hyrimoz* (adalimumab- adaz) | | Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth. Hidradenitis suppurativ HS maintenance: 40mg | va Maintenance Dose: Inject 80mg SC every other week | - | |
| (adalimumab- | Other: 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit 40mg/0.4mL Sensoready Pen 80mg/0.8mL Sensoready Pen | Other: Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40mg Alternate HS maintenan Psoriasis Initiation: Injee | va Maintenance Dose: Inject 80mg SC every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week vitis Maintenance: Inject 40mg SQ every other week va (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 g SQ every week starting on Day 29 | Refills: | |
| (adalimumabadaz) Idacio* (adalimumabadalimumabadaz) | Other: 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit 40mg/0.4mL Sensoready Pen 80mg/0.8mL Sensoready Pen 40mg/0.4mL prefilled syringe 40mg/0.8mL Prefilled Pen Plaque Psoriasis Starter Pack 40mg/0.8ml Prefilled Pen | Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40mg Alternate HS maintenar Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Psoriasis Induction Dos maintenance dosing (2 | ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ca (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 g SQ every week starting on Day 29 ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg SQ every other week ct 80mg SQ on Day 1, then 40mg SQ every other week ct 80mg SQ on Day 1, then 40mg SQ every other week ct 80mg SQ on Day 1, then 40mg SQ every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week | Refills: Quantity: Refills: | |
| (adalimumabadaz) [Idacio* (adalimumabacf) [Ilumya* (tildrakizumabasmn) *Prescriber Authorizati for our shared patient, and other pratient data coverage of the produc | Other: 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit | Dother: Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40mg Alternate HS maintenan Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Psoriasis Induction Dos maintenance dosing (2 Psoriasis Maintenance I Other: ny authorized agent, including but nefit plan sponsor, on my behalf as racy determines that it is unable to sinsurer's provider network. | and the nance Dose: Inject 80mg SC every other week act 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 80mg SQ on Day 15 SQ every week starting on Day 29 act 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week act 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week act 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 1, then 40mg SQ every 12 weeks act 80mg SQ on Day 1, then 40mg SQ every other week act 80mg SQ on Day 15 act 80mg SQ on Day | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: prior authorization process bmission of patient lab values related materials related to | |
| (adalimumabadaz) [Idacio* (adalimumabacf) [Ilumya* (tildrakizumabasmn) *Prescriber Authorizati for our shared patient, and other patient data coverage of the produc | Other: 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit 40mg/0.4mL Sensoready Pen 80mg/0.8mL Sensoready Pen 40mg/0.4mL prefilled syringe 40mg/0.8mL Prefilled Pen Plaque Psoriasis Starter Pack 40mg/0.8ml Prefilled Pen 40mg/0.8ml Prefilled Syringe 100mg/mL Prefilled Syringe | Dother: Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40mg Alternate HS maintenan Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Psoriasis Induction Dos maintenance dosing (2 Psoriasis Maintenance I Other: ny authorized agent, including but nefit plan sponsor, on my behalf as racy determines that it is unable to sinsurer's provider network. | cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ritis Maintenance: Inject 40mg SQ every other week ra (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 gSQ every week starting on Day 29 nce: 80mg SQ on Day 1, then 40mg on Day 29 cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ritis Maintenance: Inject 40mg SQ every other week ritis Maintenance: Inject 40mg SQ every other week se: Inject one pre-filled syringe (100mg) SC at weeks 0 and 4, then syringes, no refills). Dose: Inject one pre-filled syringe (100mg) SC every 12 weeks. solut limited to, attestations of medical necessity, to secure coverage and initiate the insurance my authorized agent, including any required prior authorization forms and the receipt and su fulfill this prescription, I further authorize this pharmacy to forward this information and any Date: Needs by date: Substitution Permitted | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: prior authorization process bmission of patient lab values related materials related to | |
| (adalimumabadaz) [Idacio* (adalimumabacf) [Ilumya* (tildrakizumabasmn) *Prescriber Authorization our shared patient, and other patient data coverage of the production of t | Other: Somg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit 40mg/0.4mL Sensoready Pen 80mg/0.8mL Sensoready Pen 40mg/0.4mL prefilled syringe 40mg/0.8mL Prefilled Pen Plaque Psoriasis Starter Pack 40mg/0.8ml Prefilled Pen 40mg/0.8ml Prefilled Syringe 100mg/mL Prefilled Syringe | Dother: Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40mg Alternate HS maintenan Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Psoriasis Induction Dos maintenance dosing (2 Psoriasis Maintenance I Other: ny authorized agent, including but nefit plan sponsor, on my behalf as racy determines that it is unable to sinsurer's provider network. | ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week wa (HS) induction: Inject 160mg SQ every other week wa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 SQ every week starting on Day 29 nce: 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week wittis Maintenance: Inject 40mg SQ every other week starting on Day 29 ct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week wittis Maintenance: Inject 40mg SQ every other week se: Inject one pre-filled syringe (100mg) SC at weeks 0 and 4, then syringes, no refills). Dose: Inject one pre-filled syringe (100mg) SC every 12 weeks. and limited to, attestations of medical necessity, to secure coverage and initiate the insurance may authorized agent, including any required prior authorization forms and the receipt and su fulfill this prescription, I further authorize this pharmacy to forward this information and any Date: | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: prior authorization process bmission of patient lab values related materials related to | |
| (adalimumabadaz) [Idacio* (adalimumabacf) [Ilumya* (tildrakizumabasmn) *Prescriber Authorization our shared patient, and other patient data coverage of the production of t | Other: 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit | Other: Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40mg Alternate HS maintenan Psoriasis Initiation: Injee Psoriasis/Psoriatic Arth Psoriasis Induction Dos maintenance dosing (2 Psoriasis Maintenance I Other: ny authorized agent, including but nefit plan sponsor, on my behalf as macy determines that it is unable to insurer's provider network. | cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ca (HS) induction: Inject 40mg SQ every other week ca (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 g SQ every week starting on Day 29 cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg SQ every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week cct 80mg SQ on Day 1, then 40mg on Day 29 cct 80mg SQ on Day 15 cct 80mg SQ | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: prior authorization process bmission of patient lab values related materials related to | |

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Specialty Pharmacy Enrollment Form

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| PATIENT INFO | RMATION | | PRESCRIBER INFORMA | ATION | |
|---|--|--|--|---|---|
| Please complete the following or send patient demographic sheet Patient Name | | | Prescriber's Name | FaxPhone | ation Restart cm/in |
| Other Diagno | sis: ICD-10 Code | | Concomitant Medications | <u> </u> | |
| Description Date of Diagnosis Has a TB test been performed? | | | Additional Comments | | |
| Start Date | Review Date | | Injection Training Require | d:YesNo | |
| | NINFORMATION | | | | |
| Medication Inflectra* (infliximab-dyyb) | Strength 100mg vial | and every 8 weeks there | | veek 0, week 2, week 6 | Qty/Refills Quantity: # of 100mg vial |
| (IIIIIXIIIIab-dyyb) | | Maintenance Dose: Infu | se at 5mg/kg (Dose =mg) : | IV every 8 weeks. | Refills: |
| Litfulo (ritlecitinib) | 50mg capsule | | | IV every 8 weeks. | |
| Litfulo | | Other: | time daily | IV every 8 weeks. | Refills: |
| Litfulo (ritlecitinib) | 50mg capsule | Take 50mg by mouth one ti | time daily | IV every 8 weeks. | Refills: Runtity: Refills: Quantity: |
| Litfulo (ritlecitinib) Olumiant (baricitinib) Orencia* | 50mg capsule Ing tablet 2mg tablet 4mg tablet 125mg/mL Prefilled Syringe 125mg/ml ClickJect Autoinjector 250mg vial | Take 50mg by mouth one time of the control of the c | time daily me daily. kly. ning. Day 2: 10mg PO in the morn ning and 20mg PO in the evening and 20mg PO in the evening and 30mg | ning and 10mg PO in the evening. g. g. | Refills: Quantity: Refills: Quantity: Refills: |
| Litfulo (ritlecitinib) Olumiant (baricitinib) Orencia* (abatacept) | 50mg capsule Ing tablet 2mg tablet 4mg tablet 125mg/mL Prefilled Syringe 125mg/ml ClickJect Autoinjector 250mg vial Other: | Take 50mg by mouth one is Take 2mg by mouth one tis Other: Inject 125mg SC once wee Other: Day 1: 10mg PO in the morn Day 3: 10mg PO in the morn Day 4: 20mg PO in the morn Day 5: 20mg PO in the morn Day 5: 20mg PO in the morn | me daily. kly. hing. Day 2: 10mg PO in the morning and 20mg PO in the evening and 30mg PO in the evening and 30mg PO in the evening PO twice daily. | ning and 10mg PO in the evening. g. g. | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: |
| Litfulo (ritlecitinib) Olumiant (baricitinib) Orencia* (abatacept) Otezla* (apremilast) | 50mg capsule 1mg tablet 2mg tablet 4mg tablet 125mg/mL Prefilled Syringe 125mg/ml ClickJect Autoinjector 250mg vial Other: Titration Starter Pack | Take 50mg by mouth one to Take 2mg by mouth one to Other: Inject 125mg SC once wee Other: Day 1: 10mg PO in the morn Day 3: 10mg PO in the morn Day 4: 20mg PO in the morn Day 5: 20mg PO in the morn Day 6 and thereafter: 30m Maintenance Dose: 30m Other: Induction Dose: Infuse: 8 weeks thereafter (0 re | time daily me daily. kly. hing. Day 2: 10mg PO in the morr ning and 20mg PO in the evening and 20mg PO in the evening and 30mg PO in the evening PO twice daily. mg tablet PO twice daily. forms/kg (Dose =mg) IV at verifills). see 5mg/kg (Dose =mg) IV | ning and 10mg PO in the evening. g. g. g. g. | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: 1 Pack Refills: 0 |
| Litfulo (ritlecitinib) Olumiant (baricitinib) Orencia* (abatacept) Otezla* (apremilast) Otezla* (apremilast) Remicade* (infliximab) *Prescriber Authorizati for our shared patient, and other patient data' coverage of the product | 50mg capsule 1mg tablet 2mg tablet 4mg tablet 125mg/mL Prefilled Syringe 125mg/ml ClickJect Autoinjector 250mg vial 0ther: 125mg vial 0ther: 125mg vial 0ther: 125mg vial 0ther vial vial vial vial vial vial vial vial | Take 50mg by mouth one to Take 2mg by mouth one to Other: Inject 125mg SC once wee Other: Inject 125mg SC once wee Other: Day 1: 10mg PO in the more Day 3: 10mg PO in the more Day 5: 20mg PO in the more Day 5: 20mg PO in the more Day 6 and thereafter: 30mg Other: Induction Dose: Infuse 8 weeks thereafter (0 recomposed in Maintenance Dose: Infuse Other: my authorized agent, including but neefit plan sponsor, on my behalf as reacy determines that it is unable to sinsurer's provider network. | itime daily me daily. kly. | veek 0, week 2, week 6 and every every 8 weeks. eccessity, to secure coverage and initiate the insurance prior authorization forms and the receipt and sultize this pharmacy to forward this information and any | Refills: Refills: Refills: Quantity: Refills: Refills: Refills: Refills: Quantity: Refills: Refills: Refills: # of 100mg vial Refills: # of 100mg vial Refills: # of incomplete authorization process brinsion of patient lab values related materials related to |
| Litfulo (ritlecitinib) Olumiant (baricitinib) Orencia* (abatacept) Otezla* (apremilast) Remicade* (infliximab) *Prescriber Authorizati for our shared patient, and other patient data coverage of the product | 50mg capsule 1mg tablet 2mg tablet 4mg tablet 125mg/mL Prefilled Syringe 125mg/ml ClickJect Autoinjector 250mg vial 0ther: 125mg vial 125mg vi | Take 50mg by mouth one to Take 2mg by mouth one to Other: Inject 125mg SC once wee Other: Inject 125mg SC once wee Other: Day 1: 10mg PO in the more Day 3: 10mg PO in the more Day 5: 20mg PO in the more Day 5: 20mg PO in the more Day 6 and thereafter: 30mg Other: Induction Dose: Infuse 8 weeks thereafter (0 recomposed in Maintenance Dose: Infuse Other: my authorized agent, including but neefit plan sponsor, on my behalf as reacy determines that it is unable to sinsurer's provider network. | itime daily me daily. kly. | veek 0, week 2, week 6 and every every 8 weeks. eccessity, to secure coverage and initiate the insurance prior authorization forms and the receipt and sultize this pharmacy to forward this information and any | Refills: Refills: Refills: Quantity: Refills: Refills: Refills: Refills: Quantity: Refills: Refills: Refills: # of 100mg vial Refills: # of 100mg vial Refills: # of incomplete authorization process brinsion of patient lab values related materials related to |
| Litfulo (ritlecitinib) Olumiant (baricitinib) Orencia* (abatacept) Otezla* (apremilast) Otezla* (apremilast) *Prescriber Authorizati for our shared patient, and other patient data coverage of the product Ship to: Patie | 50mg capsule 1mg tablet 2mg tablet 4mg tablet 125mg/mL Prefilled Syringe 125mg/ml ClickJect Autoinjector 250mg vial 0ther: 125mg vial 0ther: 125mg vial 0ther: 125mg vial 0ther vial vial vial vial vial vial vial vial | Take 50mg by mouth one to Take 2mg by mouth one to Other: Inject 125mg SC once wee Other: Inject 125mg SC once wee Other: Day 1: 10mg PO in the more Day 3: 10mg PO in the more Day 5: 20mg PO in the more Day 5: 20mg PO in the more Day 6 and thereafter: 30mg Other: Induction Dose: Infuse 8 weeks thereafter (0 recomposed in Maintenance Dose: Infuse Other: my authorized agent, including but neefit plan sponsor, on my behalf as reacy determines that it is unable to sinsurer's provider network. | itime daily me daily. kly. | ning and 10mg PO in the evening. g. g. g. g. g. week 0, week 2, week 6 and every every 8 weeks. excessity, to secure coverage and initiate the insurance uired prior authorization forms and the receipt and sul ize this pharmacy to forward this information and any Needs by date: Substitution Permitted | Refills: Refills: Refills: Quantity: Refills: Refills: Refills: Refills: Quantity: Refills: Refills: Refills: # of 100mg vial Refills: # of 100mg vial Refills: # of incomplete authorization process brinsion of patient lab values related materials related to |

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Specialty Pharmacy Enrollment Form

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| PATIENT INFO | PRMATION | | PRESCRIBER INFORMA | TION | |
|--|--|--|--|---|--|
| Please complete the following or send patient demographic sheet | | | Prescriber's Name | | |
| Patient Name | | | DEA | | |
| Address Address 2 City, State, Zip Home Phone Alternate Phone | | NPI Group/Hospital Address | | | |
| | | | | | |
| | | DOB Last Four of SS# Gender | | | |
| Language Preference: English Spanish Other | | | Phone Fax Contact Person Phone | | |
| | NFORMATION (Must fax a copy of patie | | cluding both sides) | | |
| | Reference number: | sire 3 misurance card in | cidaling both sides) | | |
| | ORMATION (Section must be complete | d to process procesing | tion) (Attach concrete sha | ant if annulad) | |
| | | ed to process prescrip | | Therapy: New Reauthoriza | ation Restart |
| Diagnosis – Piea | se include diagnosis name with ICD-10 code | | Additional Information | merapy: New Reauthoriza | ation Restart |
| L40.0 Psoriasis vulgaris L40.1 Generalized pustular psoriasis | | | Weight | kg/lbs Height | cm/in |
| L40.2 Acroder | matitis continua | almaris et plantaris | Allergies | | |
| L40.4 Guttate | psoriasis L40.54 Psoriatic ju | uvenile arthropathy | Lab Data | | |
| L40.59 Other | psoriatic arthropathy 🔲 L73.2 Hidradenitis | suppurativa | | | |
| L40.8 Other ps | soriasis | | Prior Inerapies | | |
| Other Diagnos | sis: ICD-10 Code | | Concomitant Medications _ | | |
| | Description | | | | |
| Date of Diagnosi | | _ | Additional Comments | | |
| · · | | - | , taartional commonto | | |
| Has a TB test bee | en performed? Yes No have an active infection? Yes No | | | | |
| · | | | Injection Training Required | : Yes No | |
| Start Date | Review Date | | | | |
| PRESCRIPTIO | N INFORMATION | | | | |
| Medication | Strength | | Dose & Directions | | Qty/Refills |
| □ n | | | 5mg/kg (Dose =mg) IV at we | eek 0, week 2, week 6 and every | Quantity: |
| | | | -EII-) | | |
| Renflexis® (infliximab-abda) | 100mg Vial | 8 weeks thereafter (0 re Maintenance Dose: Infu | efills). use 5mg/kg (Dose =mg) IV ev | very 8 weeks. | # of 100mg vial |
| | 100mg Vial | | use 5mg/kg (Dose =mg) IV ev | very 8 weeks. | # of 100mg vial Refills: |
| (infliximab-abda) | | Maintenance Dose: Info | use 5mg/kg (Dose =mg) IV e | very 8 weeks. | Refills: |
| | 100mg Vial 15mg tablet-Maintenance Dose 30mg table-Maintenance Dose | Maintenance Dose: Info | use 5mg/kg (Dose =mg) IV e | very 8 weeks. | Refills: |
| (infliximab-abda) | | Maintenance Dose: İnfu Other: Maintenance Dose: Tak Alternative Maintenance | use 5mg/kg (Dose =mg) IV ev e 15mg PO once daily e Dose: Take 30mg PO once daily | | Refills: |
| (infliximab-abda) | | Maintenance Dose: Info Other: Maintenance Dose: Tak Alternative Maintenance Inject one prefilled syringe | use 5mg/kg (Dose =mg) IV evenue. e 15mg PO once daily be Dose: Take 30mg PO once daily be (210mg) SC at weeks 0,1 and 2, for | ollowed by one prefilled syringe | Refills: Quantity: Refills: |
| (infliximab-abda) | | Maintenance Dose: Infu Other: Maintenance Dose: Tak Alternative Maintenanc Inject one prefilled syring (210mg) every 2 weeks. Pre Please visit the following R | e (210mg) SC at weeks 0,1 and 2, for escribers must be certified in the StEMS website to register before pro | | Refills: Quantity: Refills: |
| (infliximab-abda) | 15mg tablet-Maintenance Dose 30mg table-Maintenance Dose | Maintenance Dose: Infu Other: Maintenance Dose: Tak Alternative Maintenance Inject one prefilled syring (210mg) every 2 weeks. Pri | e (210mg) SC at weeks 0,1 and 2, for escribers must be certified in the StEMS website to register before pro | ollowed by one prefilled syringe SILIQ REMS Program to prescribe SILIQ. | Refills: Quantity: Refills: |
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| (infliximab-abda) Rinvoq* (upadacitinib) Siliq* (brodalumab) | 15mg tablet-Maintenance Dose 30mg table-Maintenance Dose 210mg/1.5 mL single-dose prefilled syringe | Maintenance Dose: Infu Other: Maintenance Dose: Tak Alternative Maintenance Inject one prefilled syring (210mg) every 2 weeks. Pr Please visit the following R (https://siliqrems.com/Sili | use 5mg/kg (Dose =mg) IV events and the second | ollowed by one prefilled syringe SILIQ REMS Program to prescribe SILIQ. escribing SILIQ: SILIQ REMS Website on Day 8, then 40 mg every other week | Refills: Quantity: Refills: Quantity: Refills: |
| (infliximab-abda) Rinvoq* (upadacitinib) Siliq* (brodalumab) Simlandi* (adalimumab- | 15mg tablet-Maintenance Dose 30mg table-Maintenance Dose | Maintenance Dose: Infu Other: Maintenance Dose: Tak Alternative Maintenance Inject one prefilled syrings (210mg) every 2 weeks. Pre Please visit the following R (https://siliqrems.com/Sili | use 5mg/kg (Dose =mg) IV events and the second | ollowed by one prefilled syringe SILIQ REMS Program to prescribe SILIQ. escribing SILIQ: SILIQ REMS Website on Day 8, then 40 mg every other week Q every other week I on Day 1, then 80 mg SQ on Day 15 | Refills: Quantity: Refills: |
| (infliximab-abda) Rinvoq* (upadacitinib) Siliq* (brodalumab) | 15mg tablet-Maintenance Dose 30mg table-Maintenance Dose 210mg/1.5 mL single-dose prefilled syringe | Maintenance Dose: Infu Other: Maintenance Dose: Tak Alternative Maintenanc Inject one prefilled syring (210mg) every 2 weeks. Pr Please visit the following R (https://siliqrems.com/Sili Psoriasis Initiation: Inje Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40 mg | use 5mg/kg (Dose =mg) IV events and the second | ollowed by one prefilled syringe SILIQ REMS Program to prescribe SILIQ. escribing SILIQ: SILIQ REMS Website on Day 8, then 40 mg every other week Q every other week on Day 1, then 80 mg SQ on Day 15 | Refills: Quantity: Refills: Quantity: Quantity: |
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| (infliximab-abda) Rinvoq* (upadacitinib) Siliq* (brodalumab) Simlandi* (adalimumab-ryvk) Simponi* (golimumab) | □ 15mg tablet-Maintenance Dose □ 30mg table-Maintenance Dose □ 210mg/1.5 mL single-dose prefilled syringe 40 mg/0.4mL auto-injector □ 50mg/0.5 mL SmartJect* Autoinjector □ 50mg/0.5 mL Prefilled Syringe | Maintenance Dose: Infu Other: Maintenance Dose: Tak Alternative Maintenance Inject one prefilled syring (210mg) every 2 weeks. Pre Please visit the following R (https://siligrems.com/Silie Psoriasis/Psoriatic Arth Hidradenitis suppurativ HS maintenance: 40 mg Alternate HS maintenan Psoriatic Arthritis Dose: Other: Psoriatic Arthritis Dosing: | use 5mg/kg (Dose =mg) IV events and the second | ollowed by one prefilled syringe SILIQ REMS Program to prescribe SILIQ. escribing SILIQ: SILIQ REMS Website on Day 8, then 40 mg every other week Q every other week On Day 1, then 80 mg SQ on Day 15 Other week Earting on Day 29 | Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: |
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Specialty Pharmacy Enrollment Form

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| PATIENT INFO | RMATION | | PRESCRIBER INFORMATION | | | |
|--|--|---|--|--|--|--|
| Please complete the following or send patient demographic sheet | | | Prescriber's Name | | | |
| Patient Name | | | DEA | | | |
| Address | | | NPI | | | |
| Address 2 | | | Group/Hospital | | | |
| City, State, Zip | | | Address | | | |
| Home PhoneAlternate Phone | | | City, State, ZIP Phone Fax | | | |
| DOB Last Four of SS# Gender Language Preference: English Spanish Other | | Prione | | | | |
| | | | | | | |
| | NFORMATION (Must fax a copy of pation | ent's insurance card in | cluding both sides) | | | |
| | Reference number: | | | | | |
| MEDICAL INF | ORMATION (Section must be complete | ed to process prescript | tion) (Attach separate sheet if needed) | | | |
| Diagnosis – Plea | se include diagnosis name with ICD-10 code | | Additional Information Therapy: New Read | uthorization Restart | | |
| L40.0 Psoriasis | s vulgaris L40.1 Generalized | pustular psoriasis | Weight kg/lbs Height | om /in | | |
| <u> </u> | matitis continua L40.3 Pustulosis p | | Weight kg/lbs Height cm/in | | | |
| L40.4 Guttate | | · | Allergies | | | |
| = | psoriatic arthropathy L73.2 Hidradenitis | | Lab Data | | | |
| = | . , _ | | Prior Therapies | | | |
| . | soriasis | | Concomitant Medications | | | |
| ☐ Other Diagno: | sis: ICD-10 Code | | Concomitant Medications | | | |
| | Description | | | | | |
| Date of Diagnosis | s | | Additional Comments | | | |
| Has a TB test bee | | | | | | |
| | have an active infection? Yes No | | | | | |
| Stort Data | Review Date | | Injection Training Required: Yes No | | | |
| Start Date | Review Date | - | | | | |
| PRESCRIPTIO | N INFORMATION | | | | | |
| Medication | Strength | | Dose & Directions | Qty/Refills | | |
| Skyrizi* | | | e: Inject 150mg SC at Weeks 0 and 4, then | | | |
| (risankizumab- | 150mg/mL prefilled syringe | maintenance dosing (0 | refills). Dose: Inject 150mg SC every 12 weeks. | Quantity: | | |
| rzaa) | 150mg/mL prefilled pen | Other: | | Refills: | | |
| | | | | | | |
| Sotyktu* | 6mg tablet | Take one 6mg tablet PC | | Quantity: | | |
| (deucravacitinib) | | Other: | | Refills: | | |
| | | | 100 kg (220 lbs): Inject 45mg SC initially and 4 weeks later | | | |
| | | (2 syringes, 0 refills). | 100 kg (000 lbg). This at 00mg CO initially and 4 yearly later | | | |
| Stelara* | 45mg/0.5 mL prefilled syringe | (2 syringes, 0 refills). | 100 kg (220 lbs): Inject 90mg SC initially and 4 weeks later | Quantity: | | |
| (ustekinumab) | 90mg/mL prefilled syringe | Maintenance Dose: Inje | Refills: | | | |
| | | Other: | ct 90mg SC every 12 weeks. | | | |
| | | | | | | |
| | | Psoriasis Induction Dosing | L Etwo 80mg injections on Day 1, then begin first induction dose 2 wee | ks later 8 pens/syringes | | |
| | | | ctwo borng injections on Day 1, then begin hist induction dose 2 weeks Cone 80mg injection every 2 weeks (weeks 2-10). | (State). | | |
| ☐ Taltz° | 80mg Single Dose Autoinjector | Final Induction Dose: Inject SC one 80mg injection (week 12). | | | | |
| (ixekizumab) | 80mg Single Dose Prefilled Syringe | Psoriatic Arthritis Inductio | 2 pens/syringes | | | |
| | _ | <u></u> | | | | |
| | | Maintenance Dose: 80n | ng SC once every 4 weeks. | Quantity: | | |
| | | | | Refills: | | |
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| for our shared patient, a | and to sign any necessary forms, where permitted by law and be | nefit plan sponsor, on my behalf as r | ot limited to, attestations of medical necessity, to secure coverage and initiate the my authorized agent, including any required prior authorization forms and the rece | ipt and submission of patient lab values | | |
| | and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. | | | | | |
| | | | Date: Needs by date: | | | |
| | | | Date: Needs by date: | | | |
| | Dispense as Written | | Substitution Permitted | | | |
| Prescriber's Signature | | Date | Prescriber's Signature | Date | | |
| | ignatures not accepted. | Date | Electronic or digital signatures not accepted. | Date | | |
| | | | | | | |
| Supervising/Collaborative Physician Information (per state requirements) | | | | | | |

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Specialty Pharmacy Enrollment Form This form is not a valid prescription in Arizona or Virginia ---- Please detach before submitting to a pharmacy - tear here PATIENT INFORMATION PRESCRIBER INFORMATION Please complete the following or send patient demographic sheet Prescriber's Name DEA Address Group/Hospital Address 2 City, State, Zip Address Home Phone ___ Alternate Phone City, State, ZIP ___ ___ Last Four of SS# ____ Contact Person Phone Language Preference: English Spanish Other INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides) Prior Authorization Reference number: MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed) Therapy: New Reauthorization Restart Diagnosis - Please include diagnosis name with ICD-10 code Additional Information L40.0 Psoriasis vulgaris L40.1 Generalized pustular psoriasis kg/lbs Height — Weiaht _ L40.2 Acrodermatitis continua L40.3 Pustulosis palmaris et plantaris Allergies ____ L40.4 Guttate psoriasis L40.54 Psoriatic juvenile arthropathy Lab Data ___ L40.59 Other psoriatic arthropathy L73.2 Hidradenitis suppurativa Prior Therapies _ L40.8 Other psoriasis _ Concomitant Medications ____ Other Diagnosis: ICD-10 Code ___ Description _ Additional Comments_ Date of Diagnosis _ No Yes Has a TB test been performed? Does the patient have an active infection? Yes No Injection Training Required: Yes Start Date . **Review Date** PRESCRIPTION INFORMATION Dose & Directions Qty/Refills 100mg/mL prefilled syringe Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills). Quantity: Tremfya (quselkumab) 100mg/ml One-Press Injector Maintenance Dose: Inject 100mg SC once every 8 weeks. Take one 5mg tablet PO twice daily. ☐ Xelianz[®] □5ma Tablet Quantity: Take one 11mg tablet PO once daily. 11mg XR Tablet (tofacitinib) Other: Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Yuflyma™ 40mg/0.4mL prefilled syringe Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 (adalimumab-40mg/0.4mL autoinjector Refills: HS maintenance: 40mg SQ every week starting on Day 29 aaty) Alternate HS maintenance: 80mg QV every other week starting on Day 29 Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Yusimrv" Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week 40mg/0.8mL prefilled syringe Quantity:___ 40mg/0.8mL auto-injector (adalimumab-Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 HS maintenance: 40mg SQ every week starting on Day 29 Alternate HS maintenance: 80mg QV every other week starting on Day 29 Quantity: Other Other: Other: Refills:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other Needs by date:_ **Substitution Permitted** Dispense as Written Prescriber's Prescriber's Date Date Signature Signature Electronic or digital signatures not accepted. Electronic or digital signatures not accepted. Supervising/Collaborative Physician Information (per state requirements)

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