

Dermatology Enrollment Form

Page 1 of 5 (A-C)

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form This form is not a valid prescription in Arizona ------ Please detach before submitting to a pharmacy - tear here **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 Fax_ DOB Last Four of SS# Gender Phone Language Preference: English Spanish Other Contact Person 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 Injection Training Required: Yes No **Review Date** PRESCRIPTION INFORMATION Medication Strength Dose & Directions Qty/Refills Induction Dose: Inject SC four 150 mg injections on Day 1, followed by two 150 mg injections every other week. Quantity:_ Maintenance Dose: Adbry™ 150 mg/mL prefilled syringe Inject SC two 150 ma injections every other week. Refills: ___ Inject SC two 150 mg injections every four weeks. Consideration if body weight is below 100 kg, and completed 16 weeks of treatment. Psoriasis Induction Dose: Inject 80 mg SC on day 1, followed by 40 mg SC on day 8, then 40 mg 40 mg/0.8 mL Prefilled Syringe (citrate-free) 40 mg/0.8 mL Prefilled SureClick every other week Quantity: Amjevita ™ autoinjector (citrate-free) Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. Refills: Other Other Induction Dose: Infuse 5 mg/kg (Dose = ____mg) IV at week 0, week 2, week 6 and every Quantity: Avsola⁶ 100 mg Vial # of 100 mg vial Maintenance Dose: Infuse 5 mg/kg (Dose = ____mg) IV every 8 weeks. Other: Refills: 50 mg tablet Quantity: Cibinao™ 100 mg tablet Refills: 200 mg tablet Quantity: 1 Kit Cimzia® Cimzia Starter Kit (6 prefilled syringes) Loading Dose: Inject 400mg SC (2 prefilled syringes) initially and at weeks 2 and 4. Refills: 0 Psoriasis Maintenance Dose: 400 mg (given as 2 SC of 200 mg each) every other week. 200 mg SC every other week 200 mg/1 mL Prefilled Syringe Quantity:_ Cimzia⁶ Psoriatic Arthritis Maintenance Dose: 200 mg Vial 200 mg SC every other week. Refills: __ 400 mg (given as 2 SC of 200 mg each) every 4 weeks. Psoriasis Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4 (0 refills). Psoriasis Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks Sensoready® pen 150 mg/mL injection Psoriatic Arthritis Loading Dose: (if needed): 150 mg SC at weeks 0,1,2,3, and 4 (0 refills). Quantity:_ Cosentvx* Prefilled syringe 150 mg/mL injection Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. Other: *Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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. Patient Date Product Substitution permitted Dispense as Written Prescriber's Supervising Physician Signature: Signature Date Date Electronic or digital signatures not accepted.

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Signature

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Dermatology Enrollment Form

Page 2 of 5 (D-I)

Date

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596 This form is not a valid prescription in Arizona **Specialty Pharmacy Enrollment Form** ------ 🧩 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 NPT Address 2 Group/Hospital Address City, State, Zip_ Home Phone ____ ____ Alternate Phone ___ City, State, ZIP ___ ___ Last Four of SS# ____ Phone Language Preference: English Spanish Other Contact Person Phone 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 Additional Information Therapy: New Reauthorization Restart L40.0 Psoriasis vulgaris L40.1 Generalized pustular psoriasis Weight __ _ kg/lbs Height_ 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 _ Date of Diagnosis _ Additional Comments_ Has a TB test been performed? Does the patient have an active infection? $\hfill \square$ Yes ΠNo Injection Training Required: Yes No Start Date _ Review Date PRESCRIPTION INFORMATION Adults with Atopic Dermatitis or Prurigo Nodularis: 600 mg (two 300 mg injections) followed by 300 mg Q2W 300mg/2ml Prefilled Pen Pediatric Patients with Atopic Dermatitis: Quantity: Dupixent^o 300mg/2mL Prefilled Syringe **Body Weight Initial Dose Subsequent Doses** 200mg/1.14mL Prefilled Syringe 15 to less than 30 kg 600 mg (two 300 mg injections) 300 mg Q4W Refills: ___]30 to less than 60 kg 400 mg (two 200 mg injections) 200 mg Q2W 60 kg or more 600 mg (two 300 mg injections) 300 mg Q2W 50 mg/mL Sureclick™ Autoinjector 50 mg/mL Prefilled Syringe Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3 to 4 days apart) for 3 months, 50 mg/mL Enbrel Mini™ prefilled cartridge then maintenance dosing (8 pens, 2 refills). for use with the <u>AutoTouch™ reusable</u> Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week ☐ Enbrel® Quantity: autoinjector only (Prescriber MUST supply). Psoriatic Arthritis Dose: Inject 50 mg SC ONCE a week. Refills: Avella/Briova does not order the autoinjector. Other: 25 mg/0.5 mL Prefilled Syringe 25mg/0.5ml single-dose vial Quantity: 1 Package Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Psoriasis Induction Dose: Inject 80 mg SC on day 1, followed by 40 mg SC on day 8, then 40 mg Humira® Refills: 0 Starter Package Citrate Free every other week. Quantity: 1 Package Hidradenitis Suppurativa 80 mg/0.8 mL Hidradenitis Suppurativa Induction Dose: Inject SC 160mg Day 1, then 80mg two weeks later (Day Humira® Starter Package Citrate Free Refills: 0 15), then 40mg on Day 29 and subsequent doses. 40 mg/0.4 mL Pen Citrate Free Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. Quantity:__ 40 mg/0.4 mL Prefilled Syringe **Citrate Free** Hidradenitis Suppurativa Maintenance Dose: Inject 40 mg SC every week. Humira^e Other: Other: Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then Quantity:__ maintenance dosing (2 syringes, no refills). Ilumya™ 100 mg/mL Prefilled Syringe Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks. Refills: Other: *Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fee 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. Office Other _ Patient Date Needs by Date Product Substitution permitted Dispense as Written Prescriber's Supervising

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Physician Signature: _

3173

Date



Dermatology Enrollment Form

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Specialty Pharmacy Enrollment Form

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PATIENT INFO	DRMATION		PRESCRIBER INFORM	ATION		
Please complete	the following or send patient demograph	ic sheet	Prescriber's Name			
-						
Address			NPI			
Address 2			Group/Hospital			
City, State, Zip			Address			
Home Phone Alternate Phone DOB Last Four of SS# Gender Gender			City, State, ZIP			
	ce: English Spanish Other		Contact Person Phone			
	NFORMATION (Must fax a copy of page 1		including both sides)			
	Reference number:	iciciic 3 madranec card	including both sides)			
		otod to process prescri	ntion) (Attach concrete c	hoot if pooded)		
MEDICAL INFORMATION (Section must be completed to process prescri Diagnosis – Please include diagnosis name with ICD-10 code			Additional Information		ization Restart	
Diagnosis Tiea	se include diagnosis harne with 100 10 co	1 C	Additional Information	Therapy. Thew Theadthor	izationivestart	
L20 Atopic de	L20 Atopic dermatitis L40.1 Generalized pustular psoriasis		Weight	kg/lbs Height	cm/in	
L40.0 Psoriasi	s vulgaris L40.3 Pustulos	is palmaris et plantaris	Allergies			
L40.2 Acroder	rmatitis continua 🔲 L40.54 Psoriat	c juvenile arthropathy	Lab Data			
L40.4 Guttate psoriasis L73.2 Hidradenitis suppurativa						
L40.59 Other psoriatic arthropathy			Prior Therapies			
L40.8 Other p	soriasis		Concomitant Medications			
Other Diagno	sis: ICD-10 Code Description _					
Date of Diagnosis			Additional Comments			
Has a TB test bee)	Additional commonts			
Does the patient	: have an active infection? Yes No					
Start Date	Review Date		Injection Training Required: Yes No			
PDESCRIPTION 1	N INFORMATION					
☐Inflectra [®]	100 mg vial	and every 8 weeks the	nfuse at 5 mg/kg (Dose =mg)		Quantity: # of 100 mg vial Refills:	
Orencia*	☐ 125 mg/mL Prefilled Syringe ☐ 125mg/ml ClickJect Autoinjector ☐ 250 mg vial ☐ Other:	Inject 125 mg SC once w				
Otezla*	Titration Starter Pack	Day 3: 10 mg PO in the m Day 4: 20 mg PO in the m Day 5: 20 mg PO in the m	1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. 3: 10 mg PO in the morning and 20 mg PO in the evening. 4: 20 mg PO in the morning and 20 mg PO in the evening. 5: 20 mg PO in the morning and 30 mg PO in the evening. 6 and thereafter: 30 mg PO twice daily.			
Otezla*	30 mg tablet	Maintenance Dose: 30	O mg tablet PO twice daily.		Quantity:	
Remicade°	100 mg Vial	8 weeks thereafter (0 Maintenance Dose: In	Induction Dose: Infuse 5 mg/kg (Dose =mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). Maintenance Dose: Infuse 5 mg/kg (Dose =mg) IV every 8 weeks. Other:		Quantity: # of 100 mg vial Refills:	
Renflexis*	100 mg Vial	8 weeks thereafter (0	nfuse 5 mg/kg (Dose =mg) I\		Quantity: # of 100 mg vial Refills:	
Rinvoq*	15 mg tablet-Maintenance Dose 30 mg table-Maintenance Dose	Maintenance Dose: Ta	ake 15 mg PO once daily nce Dose: Take 30 mg PO once dai	ly	Quantity:	
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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 Date Needs by Date Product Substitution permitted Dispense as Written						
Prescriber's Supervising Signature Date Physician Signature: Date Date						

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Patient

Prescriber's

Signature

Product Substitution permitted

Office

Other .

Dispense as Written

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Dermatology Enrollment Form

Needs by Date

Date

Page 4 of 5 (S-S)

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		(https://siliqrems.com/SiliqUI/home.u)	Kernis.		
☐ Simponi°	50 mg/0.5 mL SmartJect* Autoinjector 50 mg/0.5 mL Prefilled Syringe	Psoriatic Arthritis Dose: Inject 50 mg SC once a month. Other:	Quantity:		
☐ Simponi Aria*	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: <u>Induction Dose:</u> 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter (0 refills). <u>Maintenance Dose:</u> 2 mg/kg IV infusion over 30 minutes every 8 weeks.	Quantity: # of 50 mg vial Refills:		
☐Skyrizi*	☐ 150 mg/mL prefilled syringe ☐ 150 mg/mL prefilled pen	Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing (0 refills). Psoriasis Maintenance Dose: Inject 150mg SC every 12 weeks. Other:	Quantity:		
Sotyktu™	6 mg tablet	☐ Take one 6 mg tablet PO once daily. ☐ Other:	Quantity: Refills:		
□Stelara*	45 mg/0.5 mL prefilled syringe 90 mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs); Inject 45 mg SC initially and 4 weeks later (2 syringes, 0 refills). ☐ For patients weighing >100 kg (220 lbs); Inject 90 mg SC initially and 4 weeks later (2 syringes, 0 refills). ☐ Maintenance Dose; Inject 45mg SC every 12 weeks. ☐ Maintenance Dose; Inject 90mg SC every 12 weeks. ☐ Other:	Quantity: Refills:		
**Proceedings Authorize the phomograph to phomograph to accompany to accompany to the phomograph to the phomo					

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Supervising Physician Signature:

Date

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



Patient

Electronic or digital signatures not accepted.

Prescriber's

Signature

Product Substitution permitted

Office

Other

Dispense as Written

Date

Dermatology Enrollment Form

Page 5 of 5 (T-X)

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596 **Specialty Pharmacy Enrollment Form** This form is not a valid prescription in Arizona ------ 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# ____ Phone_ 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) Diagnosis - Please include diagnosis name with ICD-10 code Therapy: New Reauthorization Restart Additional Information L40.0 Psoriasis vulgaris L40.1 Generalized pustular psoriasis Weight __ __ kg/lbs Height __ L40.2 Acrodermatitis continua L40.3 Pustulosis palmaris et plantaris Allergies ___ L40.54 Psoriatic juvenile arthropathy L40.4 Guttate psoriasis 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 No Start Date _ **Review Date** PRESCRIPTION INFORMATION 8 pens/syringes Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. 80 mg Single Dose Autoinjector Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). ☐ Taltz® 80 mg Single Dose Prefilled Syringe Final Induction Dose: Inject SC one 80 mg injection (week 12). Psoriatic Arthritis Induction Dosing: 2 pens/syringes Induction Dose: 160mg SC at week 0. Maintenance Dose: 80mg SC once every 4 weeks. Refills: 100 mg/mL prefilled syringe Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills). Quantity: ☐ Tremfya® 100 mg/ml One-Press Injector Maintenance Dose: Inject 100mg SC once every 8 weeks. Refills: Take one 5 mg tablet PO twice daily. 75 mg Tablet Quantity: Xeljanz Take one 11 mg tablet PO once daily. 11 mg XR Tablet Other: Quantity: Other Other:_ Other: Refills: *Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on no behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to further process. In the patient submission of patient to another pharmacy of the patient's choice or in the patient's insurer's provider network.

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Supervising Physician Signature: _

Date

Needs by Date

Date