PSORIASIS SPECIALTY CARE PROGRAM

Phone: **888-623-3133** • Fax: **844-673-2245**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❑ M ❑ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____
ICD-10: _____ Other: _____
TB Test: ❑ Positive ❑ Negative Date: _____
LFT: ALT: _____ AST: _____ Date: _____
Assessment: ❑ Moderate ❑ Mod to Severe ❑ Severe
_____% BSA affected
❑ Scalp ❑ Face ❑ Chest ❑ Arms ❑ Hands ❑ Nails
❑ Back ❑ Groin ❑ Buttocks ❑ Legs ❑ Other: _____

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:

❑ Topicals _____
❑ Methotrexate _____
❑ Oral Meds _____
❑ Biologics _____
❑ UVA ❑ UVB _____
❑ Others _____

4 INJECTION TRAINING: ❑ Pharmacist to Provide Training ❑ Patient Trained in MD Office ❑ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❑ Patient's Home ❑ Physician's Office ❑ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ CIMZIA®	❑ 200mg/ml Prefilled Syringe	❑ Inject 400mg SC every other week		
		❑ **Induction Dose:** (Weight <90kg) Inject 400mg SC every other week initially and at weeks 2 and 4		
	❑ 200mg Lyophilized Powder Vial	❑ **Maintenance Dose:** (Weight <90kg) Inject 200mg SC every other week		
❑ COSENTYX®	❑ 150mg/ml Sensoready® Pen ❑ 150mg/ml Prefilled Syringe ❑ 150mg/ml Lyophilized Powder Vial	❑ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
		❑ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
		❑ **Maintenance Dose:** Inject 150mg SC every four weeks	1	
		❑ **Maintenance Dose:** Inject 300mg SC every four weeks	2	
❑ ENBREL®	❑ 50mg/ml Sureclick Autoinjector	❑ **Induction Dose:** Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
	❑ 50mg/ml Enbrel Mini™ Prefilled Cartridge ❑ *For Enbrel Mini™ only: AutoTouch™ Autoinjector*	❑ **Maintenance:** Inject 50mg SC once a week	4	
		Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder	1	
	❑ 50mg/ml Prefilled Syringe ❑ 25mg Lyophilized Powder Multiple Dose Vial ❑ Other: _____	❑ > 138lbs or more: Inject 50mg weekly	4	
		❑ < 138lbs: Inject 0.8mg/kg weekly		
		❑ Other: _____		
❑ HUMIRA®	❑ Psoriasis Starter Package ❑ 80mg/0.8ml Pen	❑ **Induction Dose:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	3	0
	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC every other week ❑ Other: _____	2	
	❑ Hidradenitis Suppurativa Starter Package ❑ 80mg/0.8ml Pen	❑ Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ❑ Inject one 80mg pen SC on day 1, one 80mg pen on day 2, then one 80mg pen on day 15	3	0
	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC on day 29 and every week thereafter	4	
	❑ *Patient has signed HUMIRA Complete form*			
❑ ORENCIA®	❑ 125mg/ml ClickJect™ Autoinjector ❑ 125mg/ml Prefilled Syringe	❑ Inject 125mg SC once a week	4	
❑ OTEZLA®	❑ Starter Pack (Titration)	❑ **Starter Pack:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack	1	0
	❑ 30mg Tablets	❑ **Maintenance:** Take one 30mg tablet by mouth twice daily	60	
❑ RASUVO®	❑ _____	❑ _____		
❑ SIMPONI® (for PsA)	❑ 50mg/0.5ml Smartject Injector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month	1	
❑ STELARA®		❑ **Induction Dose:** To achieve pediatric dose:		
	❑ 45mg/ml Single-Dose Vial	❑ < 60kg: Inject 0.75mg/kg		0
		❑ 60kg - 100kg: Inject 45mg SC	1	0
		❑ > 100kg: Inject 90mg SC	1	0
	❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs)	❑ Inject the contents of 1 prefilled syringe SC on day 1		
	❑ 90mg/1ml Prefilled Syringe (for > 220 lbs)	❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter	1	
	❑ Yes or ❑ No: ***STELARA SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ TREMFYA™	❑ 100mg/ml Prefilled Syringe	❑ **Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4	2	0
		❑ **Maintenance:** Inject 100mg/ml SC every 8 weeks thereafter	1	
❑ XELJANZ®	❑ 5mg Tablet	❑ Take one tablet by mouth twice daily in combination with a nonbiologic DMARD	60	
❑ XELJANZ® XR	❑ 11mg Tablet	❑ Take one tablet by mouth once daily in combination with a nonbiologic DMARD	30	
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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