Cosentino's SPECIALTY CARE

PSORIASIS AND PSORIATIC ARTHRITIS SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

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
Does patient have joint involvement? ❑ Yes ❑ No
If yes, please indicate affected joint(s):_____

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:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to 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 ❑ 200mg Lyophilized Powder Vial	**Plaque Psoriasis:** ❑ Inject 400mg SC every other week ❑ **Induction Dose:** (Weight ≤90kg) Inject 400mg SC initially and at weeks 2 and 4 ❑ **Maintenance Dose:** (Weight ≤90kg) Inject 200mg SC every other week **Psoriatic Arthritis:** ❑ **Initial:** Inject 400 mg SC initially and at weeks 2 and 4 ❑ **Maintenance:** Inject 200mg SC every other week ❑ **Maintenance:** Inject 400mg SC every 4 weeks		
❑ COSENTYX®	❑ 150mg/ml single-dose Sensoready® Pen ❑ 150mg/ml single-dose Prefilled Syringe ❑ 150mg/ml Lyophilized Powder a single-dose Vial ❑ 75 mg/0.5 mL solution in a single-dose prefilled syringe (for pediatric patients)	❑ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4 ❑ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4 ❑ **Maintenance Dose:** Inject 150mg SC every four weeks ❑ **Maintenance Dose:** Inject 300mg SC every four weeks **PsA and Enthesitis-Related Arthritis- Pediatric Patients 2 years and older:** ❑ ≥ 15 kg and < 50 kg the dose is 75 mg at 0, 1, 2, 3, and 4 and every 4 weeks thereafter. ❑ ≥ 50 kg the dose is 150 mg at 0, 1, 2, 3, and 4 and every 4 weeks thereafter.	5 10 1 2 1	0 0
❑ ENBREL®	❑ 50mg/ml Sureclick Autoinjector ❑ 50mg/ml Enbrel Mini® Prefilled Cartridge *For Enbrel Mini® only: AutoTouch® Autoinjector* ❑ 50mg/ml Prefilled Syringe ❑ 25mg/0.5ml Prefilled Syringe ❑ 25mg Lyophilized Powder Multiple Dose Vial ❑ Other: _____	❑ **Induction Dose:** Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing ❑ **Maintenance:** Inject 50mg SC once a week **Pediatric Patients:** To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder ❑ > 63 kg or more: Inject 50mg weekly ❑ < 63 kg: Inject 0.8mg/kg weekly ❑ Other: _____	8 4 4	2
❑ HUMIRA®	❑ Psoriasis 80mg/0.8ml and 40mg/0.4ml Starter Package ❑ Psoriasis 40mg/0.4ml Starter Package ❑ 40mg/0.4ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe **Hidradenitis Suppurative** ❑ Hidradenitis Suppurativa 80mg/0.8ml Starter Package ❑ Hidradenitis Suppurativa 40mg/0.4ml Starter Package ❑ 40mg/0.4ml Pen ❑ 40mg/0.8ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe *All strengths and dosages listed are Humira® Citrate Free*	**Psoriasis** ❑ **Induction Dose:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week ❑ **Maintenance:** Inject 40mg SC every other week ❑ Other: _____ **Psoriatic Arthritis** ❑ Inject 40 mg SC every other week **Induction Dose:** ❑ Inject two 80mg pens (160mg) 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 **Maintenance:** ❑ Inject 40mg SC on day 29 and every week thereafter ❑ Inject 80mg SC on day 29 and every other week thereafter ❑ *Patient has signed HUMIRA Complete form*	3 4 2 3 6 4	0 0 0 0
❑ ORENCIA®	❑ 125mg/ml ClickJect™ Autoinjector ❑ 125mg/ml Prefilled Syringe ❑ 50mg/0.4ml Prefilled Syringe ❑ 87.5mg/0.7ml Prefilled Syringe	❑ Inject 125mg SC once a week		
❑ OTEZLA®	❑ Starter Pack (Titration) ❑ 30mg Tablets	❑ **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 ❑ **Maintenance:** Take one 30mg tablet by mouth twice daily *Dosage in Severe Renal Impairment: ❑ Recommended dose is 30 mg once daily (For initial dosage titration, titrate using only morning schedule*, skip PM dose.)	1 60	0
❑ _____	_____	_____		

Rasuvo®, Rinvoq®, Simponi®, Skyrizi®, Sotyktu™, Stelara®, Taltz®, Tremfya®, Xeljanz® and Xeljanz®, Yusimry™ XR are listed alphabetically on respective enrollment forms.

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.

v9.8_112522

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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
Does patient have joint involvement? ❑ Yes ❑ No
If yes, please indicate affected joint(s):_____

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:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to 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
❑ RASUVO®	Single-dose auto-injector prefilled syringe: ❑ 7.5mg ❑ 10mg ❑ 12.5mg ❑ 15mg ❑ 17.5mg ❑ 20mg ❑ 22.5mg ❑ 25mg ❑ 27.5 mg ❑ 30mg	❑ Inject ____ mg SC once weekly *An initial test dose of 2.5 to 5 mg is recommended in patients with risk factors for hematologic toxicity or renal impairment*		
❑ RINVOQ®	❑ 15mg ER Tablets	❑ Take 15mg tablet once daily	30	
❑ SIMPONI® (for PSA)	❑ 50mg/0.5ml prefilled syringe ❑ 50mg/0.5ml prefilled SmartJect® autoinjector	❑ Inject 50mg SC once a month	1	
❑ SKYRIZI®	❑ 150 mg/ml in each single-dose prefilled pen ❑ 150 mg/ml in each single-dose prefilled syringe ❑ Yes or ❑ No: ***SKYRIZI SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*	❑ **Induction Dose:** Inject 150mg SC at weeks 0 and 4 ❑ **Maintenance:** Inject 150mg SC every 12 weeks thereafter	2 1	0
❑ SOTYKTU™	❑ 6 mg Tablet	❑ Take 6 mg tablet orally once daily, with or without food	30	
❑ STELARA®	❑ 45mg/0.5 ml Single-Dose Prefilled Syringe ❑ 45mg/0.5 ml Solution in a Single-Dose Vial ❑ 90mg/1ml Prefilled Syringe (for > 100 kg)	**Plaque Psoriasis Adult Dose:** ❑ Adult dosing (≤100 kg): Inject 45 mg SC initially and at 4 weeks, then every 12 weeks thereafter ❑ Adult Dosing (>100 kg): Inject 90 mg SC initially and at 4 weeks, then every 12 weeks thereafter **Psoriasis Pediatric Dose (6 to 17 years old):** ❑ < 60kg - 100kg: Inject 45 mg SC initially at 4 weeks, then every 12 weeks thereafter ❑ 60kg - 100kg: Inject 45 mg SC initially at 4 weeks, then every 12 weeks thereafter ❑ > 100kg: Inject 90 mg SC initially at 4 weeks, then every 12 weeks thereafter **Psoriatic Arthritis Adult Dose:** ❑ Inject 45 mg SC initiation and at 4 weeks, then every 12 weeks thereafter **Adult Psoriatic Arthritis: Co-existent moderate-to-severe plaque psoriasis weighing** ❑ >100 kg: Inject 90 mg SC initially and at 4 weeks,then every 12 weeks thereafter **Psoriatic Arthritis Pediatric Dose (6 to 17 years old):** ❑ < 60kg: Inject Inject 0.75 mg/kg SC initially at 4 weeks, then every 12 weeks thereafter ❑ > 60kg: Inject 45mg SC initially at 4 weeks, then every 12 weeks thereafter ❑ > 100kg with co-existent moderate-to-severe plaque psoriasis: Inject 90 mg SC initially at 4 weeks, then every 12 weeks thereafter		
❑ _____	_____	_____		

Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia® and Otezla® are listed alphabetically on respective enrollment forms.

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**

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Name: _____
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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
Does patient have joint involvement? ❑ Yes ❑ No
If yes, please indicate affected joint(s):_____

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:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

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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
❑ TALTZ®	❑ 80mg/ml Single-Dose Prefilled Autoinjector ❑ 80mg/ml Single-Dose Prefilled Syringe	**Psoriatic Arthritis (PsA):** ❑ Induction Dose: Inject 160 mg SC (two 80 mg injections) at week 0 ❑ Maintenance: Inject 80 mg SC every 4 weeks thereafter		
		Plaque Psoriasis or PsA with Coexistent Moderate-to-Severe Plaque Psoriasis: ❑ **Weeks 0-2:** Inject 160mg SC (two 80mg injections) at weeks 0, then inject 80mg SC at week 2	3	0
		❑ **Weeks 4-10:** Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	4	0
		❑ **Week 12 and onwards:** Inject 80mg SC at week 12 and every 4 weeks thereafter		
❑ TREMFYA®	❑ 100mg/ml Prefilled Syringe ❑ 100mg/ml One- Press Patient Controlled Injector	❑ **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	
❑ YUSIMRY™	❑ 40mg/0.8ml Prefilled Syringe	**Psoriatic Arthritis:** ❑ Inject 40mg SC every other week		
		Plaque Psoriasis: ❑ **Induction Dose:** Inject 80mg SC on day one ❑ **Maintenance Dose:** Inject 40mg SC every other week starting on one week after initial dose		
❑ _____	_____	_____		

Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia® and Otezla® are listed alphabetically on respective enrollment forms.

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**

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