

Cosentino's PSORIASIS AND PSORIATIC ARTHRITIS SPECIALTY CARE PROGRAM

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

KLOUDSCRIPT	17
Community Led Specialty Pharmacy Care	IS

	NFORMATION:	2 PRESCRIBER INFORMATION:			
Address:	<u>-</u>	Address:			
	State: Zip:				
	Alt. Phone:				
:mail:		NPI: DEA:			
	_ Gender: O M O F Caregiver: _	Tax I.D.:			
leight:	Weight: Allergies:	Tax I.D.: Phone:			
Date of Diagnosis:	IT OF MEDICAL NECESSITY	(Please Attach All Medical Documentation) attent also taking Methotrexate? Yes INO Topicals Topicals			
CD-10:		erious or active infection present?	☐ Methotrexate		
IB lest: U Positive	Date:				
-FI: ALI: Seeseemant: □ Mo		loes patient have joint involvement? Yes No			
% BSA affect	tod	yes, please indicate affected joint(s): Biologics			
 □ Scalp □ Face □	I Chest □ Arms □ Hands □ Nails	If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.	☐ Oral Meds ☐ Biologics ☐ UVA ☐ UVB ☐ Others		
1 INJECTION	TRAINING: O To Be Administered by Pha	urmacist (State of Missouri Only) O Pharmacist to Provide Training O Patient Trained in MD Office O Manufactur	er Nurse Su	pport	
-		ent's Home O Delivery to Physician's Office O Pharmacy to Coor			
_			umate		
PRESCRIPTION	I INFORMATION: (Please be sur	Front and Back Copies of Pharmacy and Medical Card re to choose both induction and maintenance dose where applica	able)		
atient Name:		Patient's Date of Birth:			
Medication	Dosage & Strength	Direction Plaque Psoriasis:	QTY	Refills	
□ CIMZIA®	☐ 200mg/ml Prefilled Syringe☐ 200mg Lyophilized Powder Vial	☐ 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			
	☐ 150mg/ml single-dose Sensoready® Pen	Industrian Deep Inject 150mg SC at works 0. 1. 2. 2 and 4			
	150mm/ml single dage Duefilled Conings	Induction Describing 30 at weeks 0, 1, 2, 3, and 4	5	0	
	☐ 150mg/ml single-dose Prefilled Syringe ☐ 150mg/ml Lyophilized Powder a single-dose Vial	☐ 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	10	0	
□ COSENTYX®	☐ 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 syri (for pediatric patients)	☐ Maintenance Dose: Inject 150mg SC every four weeks	10		
□ COSENTYX®	 ☐ 150mg/ml Lyophilized Powder a single-dose Vial ☐ 75 mg/0.5 mL solution in a single-dose prefilled syri 		10 1 2		
	□ 150mg/ml Lyophilized Powder a single-dose Vial □ 75 mg/0.5 mL solution in a single-dose prefilled syri (for pediatric patients) □ 50mg/ml Sureclick Autoinjector □ 50mg/ml Enbrel Mini® Prefilled Cartridge For	Maintenance Dose: Inject 150mg SC every four weeks Maintenance Dose: Inject 300mg 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. 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	10 1 2 1	0	
	□ 150mg/ml Lyophilized Powder a single-dose Vial □ 75 mg/0.5 mL solution in a single-dose prefilled syri (for pediatric patients) □ 50mg/ml Sureclick Autoinjector	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. Induction Dose: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	10 1 2 1	0	
	□ 150mg/ml Lyophilized Powder a single-dose Vial □ 75 mg/0.5 mL solution in a single-dose prefilled syri (for pediatric patients) □ 50mg/ml Sureclick Autoinjector □ 50mg/ml Enbrel Mini® Prefilled Cartridge For Enbrel Mini® only: Auto Touch® Autoinjector □ 50mg/ml Prefilled Syringe □ 25mg/0.5ml Prefilled Syringe □ 25mg Lyophilized Powder Multiple Dose Vial □ Other: □ Psoriasis 80mg/0.8ml and 40mg/0.4ml Starter Pack	Maintenance Dose: Inject 150mg SC every four weeks Maintenance Dose: Inject 300mg SC every four weeks Maintenance Dose: Inject 300mg SC every four weeks	10 1 2 1 8 4	2	
	□ 150mg/ml Lyophilized Powder a single-dose Vial □ 75 mg/0.5 mL solution in a single-dose prefilled syri (for pediatric patients) □ 50mg/ml Sureclick Autoinjector □ 50mg/ml Enbrel Mini® Prefilled Cartridge For Enbrel Mini® only: AutoTouch® Autoinjector □ 50mg/ml Prefilled Syringe □ 25mg Lyophilized Powder Multiple Dose Vial □ Other: □ Psoriasis 80mg/0.8ml and 40mg/0.4ml Starter Package □ 40mg/0.4ml Pen	Maintenance Dose: Inject 150mg SC every four weeks Maintenance Dose: Inject 300mg SC every four weeks Maintenance Dose: Inject 300mg SC every four weeks	10 1 2 1 8 4 4	0	
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□ COSENTYX® □ ENBREL® □ HUMIRA® □ ORENCIA® □ OTEZLA®	□ 150mg/ml Lyophilized Powder a single-dose Vial □ 75 mg/0.5 mL solution in a single-dose prefilled syri (for pediatric patients) □ 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: □ Psoriasis 80mg/0.8ml and 40mg/0.4ml Starter Pack □ 9soriasis 40mg/0.4ml Starter Package □ 40mg/0.4ml Pen □ 40mg/0.4ml Prefilled Syringe □ 80mg/0.8ml Prefilled Syringe □ Hidradenitis Suppurative □ Hidradenitis Suppurativa 40mg/0.4ml Starter Package □ Hidradenitis Suppurativa 40mg/0.4ml Starter Package □ Hidradenitis Suppurativa 40mg/0.4ml Starter Package □ 40mg/0.4ml Pen □ 40mg/0.4ml Pen □ 40mg/0.8ml Pen □ 40mg/0.4ml Prefilled Syringe □ 125mg/ml ClickJect™ Autoinjector □ 125mg/ml ClickJect™ Autoinjector □ 125mg/ml Prefilled Syringe □ 50mg/0.4ml Prefilled Syringe □ 50mg/0.4ml Prefilled Syringe □ 50mg/0.4ml Prefilled Syringe □ 50mg/0.4ml Prefilled Syringe	Maintenance Dose: Inject 150mg SC every four weeks Maintenance Dose: Inject 300mg SC every four weeks Maintenance Dose: Inject 300mg SC every four weeks 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. 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: 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 Induction Dose: Inject 40mg SC every other week Inject 40 mg SC every other week Inject 40 mg SC every other week Inject two 80mg pens (160mg) SC on day 1, then one 80mg pen SC on day 15 Inject one 80mg pen SC on day 29 and every week thereafter 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 Inject 125mg SC once a week Inject 125mg SC once	10 1 2 1 8 4 4 4 2 3 4 2	0 0 0 0	

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

PRESCRIBER SIGNATURE: laur	thorize pharmacy to act as my designee	for initiating and coordinating insurance	e 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	r based upon the patient's eligibility, medical necess	ity, 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.



PSORIASIS AND PSORIATIC ARTHRITIS SPECIALTY CARE PROGRAM

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



PATIENT IN			2 PRESCRIBER INFORMATION: Name:				
City:	State: Zip:			State: Zi	o:		
	Alt. Phone:						
Email:							
OOB:	Gender: O M O F Caregiver:	Tax I.D.:					
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	N INFORMATION: (Please by Dosage & Strength			ance dose where a		ole)	
	Single-dose auto-injector prefilled syringe:	☐ Inject mg SC once weekly			\top		
☐ RASUVO [®]	☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 27.5 mg ☐ 30mg	*An initial test dose of 2.5 to 5 mg i factors for hematologic toxicity or r		vith risk			
☐ RINVOQ [®]	☐ 15mg ER Tablets	☐ Take 15mg tablet once daily			30		
SIMPONI® (for PSA)	☐ 50mg/0.5ml prefilled syringe ☐ 50mg/0.5ml prefilled SmartJect® autoinject	or Inject 50mg SC once a month			1		
	☐ 150 mg/ml in each single-dose prefilled pen	☐ Induction Dose: Inject 150mg S	C at weeks 0 and 4		2	0	
☐ SKYRIZI [®]	☐ 150 mg/ml in each single-dose prefilled syringe	☐ Maintenance: Inject 150mg SC ev	intenance: Inject 150mg SC every 12 weeks thereafter				
	, ,	hcare provider certifies that patient has been tr	er certifies that patient has been trained and is eligible for self-injection				
☐ SOTYKTU™	☐ 6 mg Tablet	☐ Take 6 mg tablet orally once dai	ly, 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 then every 12 weeks thereafter ☐ Adult Dosing (>100 kg): Inject 90 then every 12 weeks thereafter	0 mg SC initially and at 4 wee				
		Psoriasis Pediatric Dose (6 to 17 <a> 60kg - 100kg: Inject 45 mg SC <a> 60kg - 100kg: Inject 45 mg SC inj	D initially at 4 weeks, then even nitially at 4 weeks, then every	12 weeks thereafter			
		Psoriatic Arthritis Adult Dose: Inject 45 mg SC initiation and at	4 weeks, then every 12 week	ks thereafter			
		Adult Psoriatic Arthritis: Co-exist ☐ >100 kg: Inject 90 mg SC initiall					
	Psoriatic Arthritis Pediatric Dose	SC initially at 4 weeks, then eat 4 weeks, then every 12 wereate-to-severe plaque psoriasi	eks thereafter is:				
		rencia® and Otezla® are listed alph	nabetically on respective	enrollment forms.			
	R SIGNATURE: I authorize pharmacy to						
PRESCRIBER	1 SIGNATURE: Lauthorize pharmacy to	act as my designee for initiating and coordinate	ting insurance prior authorization	s, nursing services and patient	assistance pr	rograms.	

Signature: _____ Date: _____ Signature: _____ Dispense As Written

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.



PSORIASIS AND PSORIATIC ARTHRITIS SPECIALTY CARE PROGRAM

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



1 PATIENT IN			2 PRESCRIBER				
			Name:				
	State: Zip:						
	Alt. Phone:		Phone:				
Email:			NPI:		DEA:		
DOB:	Gender: O M O F Caregiver	• •	Tax I.D.:				
Height:	Gender: OM OF Caregiver Weight: Allergies:		Office Contact:		Phone:		
	T OF MEDICAL NECESSIT				Prior Failed Treat		
Date of Diagnosis: Pa		Patient also taking Methotrexate? ☐ Yes ☐ No			□ Topicals		
ICD-10:	CD-10:Other: Serious or active B Test: D Positive Date: Serious or active B Test: D Positive Date:		Serious or active infection present?				
TB Test: ☐ Positive				s 🗆 No	☐ Methotrexate☐ Oral Meds		
Assessment: Mos	AST: Date: derate \(\begin{array}{c} \text{Mod to Severe} \(\begin{array}{c} \text{Severe} \end{array} \)	Does patient hav	e joint involvement? Yes				
% BSA affecte			licate affected joint(s):		■ Biologics		
	Chest ☐ Arms ☐ Hands ☐ Nails		ion is denied, recommended tives will be provided to the pre	escriber	UVA UVB		
	Buttocks 🛘 Legs 🖨 Other:		atient's insurance coverage.		Others		
4 INJECTION	TRAINING: O To Be Administered by	Pharmacist (State of Missou	ri Only) O Pharmacist to Provide Training	g O Patient T	rained in MD Office O Manu	acturer Nurse	Support
PICK UP OR	DELIVERY: O Delivery to Pa	atient's Home	O Delivery to Physician's	s Office	O Pharmacy to C	oordinat	Support
6 INSURANCI	E INFORMATION: Please In	clude Front and	Back Copies of Pharm	acy and I	Medical Card		
	N INFORMATION: (Please b			maintena	nce dose where	applicat	ole)
Patient Name:	D 0.01 II				Birth:	OTV	Refills
Medication	Dosage & Strength		Direction	on		QIY	Refills
			itis (PsA): ose: Inject 160 mg SC (two 80 mg in e: Inject 80 mg SC every 4 weeks the	•	eek 0		
☐ TALTZ®	☐ 80mg/ml Single-Dose Prefilled Autoinjecto	or -	sis or PsA with Coexistent Moderat Inject 160mg SC (two 80mg injectio week 2		-	3	0
		☐ Weeks 4-10	eeks 4-10: Inject 80mg SC at week 4 and every 2 weeks thereafter through week			4	0
		☐ Week 12 an	12 and onwards: Inject 80mg SC at week 12 and every 4 weeks thereafter				
D TDEMENA®	☐ 100mg/ml Prefilled Syringe	☐ Induction D	nduction Dose: Inject 100mg/ml SC at weeks 0 and 4		2	0	
☐ TREMFYA®	☐ 100mg/ml One- Press Patient Controlled Injector	☐ Maintenand	☐ Maintenance: Inject 100mg/ml SC every 8 weeks thereafter			1	
☐ XELJANZ®	☐ 5mg Tablet	☐ Take one tab	olet by mouth twice daily in combina	tion with a no	nbiologic DMARD	60	
☐ XELJANZ® XR	☐ 11mg Tablet	☐ Take one tak	olet by mouth once daily in combinate	tion with a nor	nbiologic DMARD	30	
		Psoriatic Arth ☐ Inject 40mg	nritis: SC every other week				
☐ YUSIMRY™	☐ 40mg/0.8ml Prefilled Syringe		ose: Inject 80mg SC on day one te Dose: Inject 40mg SC every other	r week starting	g on one week		
	_						
	Cimzia®, Cosentyx®, Enbrel®, Humira®,	Orencia® and Otezla	a® are listed alphabetically on	respective	enrollment forms.	<u> </u>	
	R SIGNATURE: Lauthorize pharmacy		<u> </u>			accietanas =	rograme
Signature:		ate:	Signature:	additorizations	batiening services and patient		ogranio.

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 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 and participation. This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.

Dispense As Written

Substitution Permitted