				Dermatology Enrollment Form Page 1 of 4 (A-H)				
Specialty Pharm	nacy Enrollment Form 🦗 Pl	ease detach before submit	itting to a pharmacy – tear here.					
PATIENT INFO	RMATION		PRESCRIBER INFORM	ATION				
Please complete	e the following or send patient demographic sl	heet	Prescriber's Name					
			DEA					
Address Address 2				NPI Group/Hospital				
City, State, Zip			Address					
	Alternate Phone			City, State, ZIP Phone				
	_ Last Four of SS# Gender nce:		Phone Contact Person					
	NFORMATION (Must fax a copy of patient							
	Reference number:		Icidaling Both Sideo,					
	DRMATION (Section must be completed	to process prescrip	tion) (Attach separate sh	eet if needed)				
	ease include diagnosis name with ICD-10 code		Additional Information		New Reauthoriza	ation Restart		
L40.0 Psoriasi	sis vulgaris L40.1 Generalized	oustular psoriasis	Weight	ka/lbs	 Height	cm/in		
	ermatitis continua		, v	Weight kg/lbs Height cm/in				
L40.4 Guttate		•	Allergies					
	psoriatic arthropathy L73.2 Hidradenitis							
L40.8 Other p	osoriasis		Prior Therapies					
Other Diagno	osis: ICD-10 Code		Concomitant Medication	s				
	Description							
Date of Diagnos	is		Additional Comments					
	t have an active infection? Yes No		Injection Training Required: Yes No					
	Review Date							
PRESCRIPTION Medication	N INFORMATION Strength		Dose & Directio			Qty/Refills		
Medication	Suengui	l	D036 & Dilectio	ins		Qty/nelliis		
Cimzia®	Cimzia Starter Kit (6 prefilled syringes)	Loading Dose: Inject	t 400mg SC (2 prefilled syringes) i	nitially and at weeks	2 and 4.	Quantity: 1 Kit Refills: 0		
Cimzia®	☐ 200 mg/1 mL Prefilled Syringe ☐ 200 mg Vial	400 mg (given as 2 S 200 mg SC every oth Psoriatic Arthritis Maintee 200 mg SC every oth 400 mg (given as 2 S				Quantity: Refills:		
Cosentyx®	☐ Sensoready [®] pen 150 mg/mL injection ☐ Prefilled syringe 150 mg/mL injection	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. Psoriatic Arthritis Loading Dose: (if needed): 150 mg SC at weeks 0,1,2,3, and 4 (0 refills). Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. Other:			Quantity: Refills:			
Enbrel®	 50 mg/mL Sureclick™ Autoinjector 50 mg/mL Prefilled Syringe 50 mg/mL Enbrel Mini™ prefilled cartridge for use with the <u>AutoTouch™ reusable</u> <u>autoinjector only</u> (Prescriber MUST supply). Avella/Briova does <u>not</u> order the autoinjector. 25 mg/0.5 mL Prefilled Syringe 25 mg vial 	Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing (8 pens, 2 refills). Quantity: Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week. Quantity: Psoriatic Arthritis Dose: Inject 50 mg SC ONCE a week. Refills: Other: Other:			Quantity: Refills:			
behalf as my authorize	ion: I authorize this pharmacy and its representatives to act as my ed agent, including the receipt of any required prior authorization rer authorize this pharmacy to forward this information and any re	forms and the receipt and subm elated materials related to covera	nission of patient lab values and other pa rage of the product to another pharmacy	atient data. In the event the of the patient's choice of	hat this pharmacy determines th or in the patient's insurer's provid	nat it is unable to fulfill ler network.		
Ship to: Patient Office Other Date Date Needs by Date								
Product Substitution permitted Dispense as Written								
Prescriber's Supervising Signature Date Date Date Physician Signature: Date								
Signature Electronic or digital sig		э Р	² hysician Signature:		Dat	(e		
CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.								

				Dermatology Enrollment Form Page 2 of 4 (I-S)			
Specialty Phar	macy Enrollment Form 🛛 🖗 P	lease detach before submit	tting to a pharmacy – tear here.				
PATIENT INFO	RMATION		PRESCRIBER INFORM	IATION			
Please complete the following or send patient demographic sheet			Prescriber's Name				
Patient Name			DEA NPI				
			Group/Hospital				
			Address				
	Alternate Phone _ Last Four of SS# Gender		City, State, ZIP Phone				
	_ Last roll of 35# Gender nce: English Spanish Other		Contact Person				
INSURANCE I	NFORMATION (Must fax a copy of patien	ts insurance card ir	ncluding both sides)				
	Reference number:						
MEDICAL INF	ORMATION (Section must be completed	to process prescrip	tion) (Attach separate sh	eet if needed)			
Diagnosis — Ple	ease include diagnosis name with ICD-10 code	9	Additional Information	Therapy:	New Reauthoriza	ition Restart	
L40.0 Psorias	sis vulgaris 🗌 L40.1 Generalized	pustular psoriasis	Weight	kg/lbs	Height	cm/in	
L40.2 Acrode	ermatitis continua 🗌 L40.3 Pustulosis p	palmaris et plantaris	Weight kg/lbs Height cr Allergies Allergies				
L40.4 Guttate	e psoriasis 🗌 L40.54 Psoriatic ju	uvenile arthropathy	Lab Data				
L40.59 Other	psoriatic arthropathy 🗌 L73.2 Hidradenitis	suppurativa	Prior Therapies				
	osoriasis						
Other Diagno	osis: ICD-10 Code		Concomitant Medication				
	Description						
	sis		Additional Comments				
Has a TB test been performed? Yes No Does the patient have an active infection? Yes No Start Date		Injection Training Required: Yes No					
	N INFORMATION						
PRESCRIPTIO							
☐ Humira®	Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package Citrate Free	every other week.	<u>Dose:</u> Inject 80 mg SC on day 1, fo		on day 8, then 40 mg	Quantity: 1 Package Refills: 0	
☐ Humira®	Hidradenitis Suppurativa 80 mg/0.8 mL Starter Package Citrate Free	Hidradenitis Suppura	······································			Quantity: 1 Package Refills: 0	
Humira®	40 mg/0.4 mL Pen Citrate Free 40 mg/0.4 mL Prefilled Syringe Citrate Free Other:	Hidradenitis Suppura	<u>tic Arthritis Maintenance Dose:</u> Inject 40mg SC every other week. p <u>urativa Maintenance Dose:</u> Inject 40 mg SC every week. 			Quantity: Refills:	
Ilumya™	100 mg/mL Prefilled Syringe	Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 a maintenance dosing (2 syringes, no refills). Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 Other:				Quantity: Refills:	
☐ Inflectra®	100 mg vial	☐ <u>Induction Dose</u> ; Infuse 5 mg/kg (Dose =mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ <u>Maintenance Dose</u> ; Infuse at 5 mg/kg (Dose =mg) IV every 8 weeks. ☐ Other:			eks.	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 v	weekly.		-	Quantity: Refills:	
behalf as my authorize	I tion: I authorize this pharmacy and its representatives to act as m ed agent, including the receipt of any required prior authorization her authorize this pharmacy to forward this information and any r	forms and the receipt and subm	nission of patient lab values and other pa	atient data. In the event t	hat this pharmacy determines th	at it is unable to fulfill	
			Date				
					, <u> </u>		
Prescriber's	stitution permitted Dispense as Writte		Supervising				
Signature	Dat	e F	Physician Signature:		Dat	(e	
	gnatures not accepted.						
of this communication	TEMENT: This communication is intended for the use of the individu is not the intended recipient or the employee or agent responsible ication in error, please notify us immediately by telephone.						

OPTUM®				Dermatology Enrollment Form Page 3 of 4 (S-X)			
Specialty Pharmacy Enrollment Form 🖗 Please detach before submitting to a pharmacy – tear here.							
PATIENT INFO	RMATION		PRESCRIBER INFORM	IATION			
Please complete the following or send patient demographic sheet			Prescriber's Name				
Patient Name			DEA				
Address Address 2			NPI				
			Group/Hospital Address				
	Alternate Phone		City, State, ZIP				
	_ Last Four of SS# Gender nce:		Phone Fax Contact Person Phone				
	NFORMATION (Must fax a copy of patien						
	Reference number:						
	DRMATION (Section must be completed	to process prescrip	tion) (Attach separate sh	eet if needed)			
	ase include diagnosis name with ICD-10 code		Additional Information		New Reauthoriza	ition Restart	
L40.0 Psoriasi	is vulgaris 🗌 L40.1 Generalized	pustular psoriasis	Weight	ka/lbs	Height		
	rmatitis continua		Weight kg/lbs Height Allergies				
L40.4 Guttate		•					
	psoriatic arthropathy 🗌 L73.2 Hidradenitis		Lab Data				
L40.8 Other p	soriasis		Prior Therapies				
Other Diagno	osis: ICD-10 Code		Concomitant Medication	s			
	Description						
Date of Diagnos	is		Additional Comments				
	een performed?						
Does the patient	t have an active infection? Yes No		Inication Training Desuit				
Start Date	Review Date		Injection Training Requir] NO		
PRESCRIPTION	N INFORMATION						
☐ Otezla®	Titration Starter Pack	Day 3: 10 mg PO in the r Day 4: 20 mg PO in the	norning. Day 2: 10 mg PO in the m morning and 20 mg PO in the eve morning and 20 mg PO in the eve morning and 30 mg PO in the eve morning and 30 mg PO in the eve mg PO twice daily.	ning.) in the evening.	Quantity: 1 Pack Refills: 0	
Otezla®	30 mg tablet		30 mg tablet PO twice daily.			Quantity: Refills:	
Remicade®	100 mg Vial	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	Induction Dose; Infuse 5 mg/kg (Dose =mg) IV at week 0, week 2, w 8 weeks thereafter (0 refills). <u>Maintenance Dose;</u> Infuse 5 mg/kg (Dose =mg) IV every 8 weeks. Other:				Quantity: # of 100 mg vial Refills:	
	☐ 210 mg/1.5 mL single-dose prefilled syringe	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one pr every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to pre			refilled syringe (210 mg) escribe SILIQ.	Quantity:	
		(https://siliqrems.com/Sil	Please visit the following REMS website to register before prescribing SILIQ: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)			Refills:	
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: Refills:	
Simponi Aria®	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: ☐ Induction Dose; 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then 8 weeks thereafter (0 refills). ☐ Maintenance Dose; 2 mg/kg IV infusion over 30 minutes every 8 weeks.				Quantity: # of 50 mg vial Refills:	
*Prescriber Authorized from: 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 insurer's provider network.							
Ship to: Patient Office Other Date Date Deter Deter Deter Needs by Date							
Product Substitution permitted Dispense as Written							
Prescriber's Supervising Signature Date Physician Signature:							
Signature Electronic or digital sig	Dat	e P	nysician Signature:		Da	te	
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				Dermatology Enrollment Form Page 4 of 4 (S-X)			
Specialty Pharmacy Enrollment Form 🖗 Please detach before submitting to a pharmacy – tear here.							
PATIENT INFO	RMATION		PRESCRIBER INFORM	ATION			
Please complete the following or send patient demographic sheet			Prescriber's Name				
			DEA				
Address Address 2			NPI Group/Hospital				
City, State, Zip			Address				
	Alternate Phone		City, State, ZIP				
	_ Last Four of SS# Gender nce:		Phone Fax Contact Person Phone				
	NFORMATION (Must fax a copy of patien		ludina both sides)				
	Reference number:		5				
MEDICAL INFO	ORMATION (Section must be completed	to process prescription	on) (Attach separate sh	eet if needed)			
Diagnosis — Ple	ease include diagnosis name with ICD-10 code	;	Additional Information	Therapy:	New Reauthoriza	tion Restart	
L40.0 Psorias	sis vulgaris 🗌 L40.1 Generalized	pustular psoriasis	Weight	kg/lbs	Height	cm/in	
L40.2 Acrode	ermatitis continua 🛛 L40.3 Pustulosis p		Allergies	-	-		
L40.4 Guttate	e psoriasis 🗌 L40.54 Psoriatic ju	uvenile arthropathy	Lab Data				
L40.59 Other	psoriatic arthropathy Dr73.2 Hidradenitis	suppurativa	Prior Therapies				
	osoriasis						
Other Diagno	osis: ICD-10 Code		Concomitant Medication	s			
	Description						
Date of Diagnos	is		Additional Comments				
	een performed? Yes No t have an active infection? Yes No						
	Review Date		Injection Training Requir	ed: Yes	No		
PRESCRIPTIO							
Skyrizi®	75 mg/0.83 mL prefilled syringe	maintenance dosing (ose: Inject 150 mg (two injections 0 refills). 9 Dose: Inject 150mg (two injecti	ons) SC every 12 wee		Quantity: Refills:	
Stelara®	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	 <u>For patients weighing ≤100 kg (220 lbs)</u>: Inject 45 mg SC initially and 4 weeks later (2 syringes, 0 refills). <u>For patients weighing >100 kg (220 lbs)</u>: Inject 90 mg SC initially and 4 weeks later (2 syringes, 0 refills). 			Quantity: Refills:		
☐ Taltz®	80 mg Single Dose Autoinjector 80 mg Single Dose Prefilled Syringe	Psoriasis Induction Dosing: Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). Final Induction Dose: Inject SC one 80 mg injection (week 12). Psoriatic Arthritis Induction Dosing: Induction Dose: 160mg SC at week 0.				2 pens/syringes	
		Maintenance Dose: 80mg SC once every 4 weeks.			Quantity:		
					Refills:		
☐ Tremfya®	100 mg/mL prefilled syringe	Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens,) refills).	Quantity:	
	100 mg/ml One-Press Injector	Maintenance Dose: Inject 100mg SC once every 8 weeks.				Refills:	
_ Xeljanz®	☐ 5 mg Tablet ☐ 11 mg XR Tablet	Take one 5 mg tablet f Take one 11 mg tablet Other:	PO twice daily. PO once daily.		_	Quantity: Refills:	
Other	Other:	I				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.							
Product Substitution permitted Dispense as Written							
Prescriber's Supervising							
Signature Date Date Physician Signature: Date							
Electronic or digital signatures not accepted.							
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