Optum

Dermatology Enrollment Form

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

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here

This form is not a valid prescription in Arizona or Virginia

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____

Address _____

Address 2 _____

City, State, Zip _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

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

☐ L20 Atopic dermatitis
☐ L28.1 Prurigo nodularis
☐ L40.0 Psoriasis vulgaris
☐ L40.2 Acrodermatitis continua
☐ L40.4 Guttate psoriasis
☐ L40.1 Generalized pustular psoriasis
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis _____
☐ Other Diagnosis: ICD-10 Code _____ Description _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Abrilada™ (adalimumab-afzb)	☐ 20mg/0.4mL prefilled syringe ☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL pen	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity:_____ Refills: _____
☐ Adbry® (tralokinumab-ldrm)	150mg/mL prefilled syringe	Induction Dose: Inject SC four 150mg injections on Day 1, followed by two 150mg injections every other week. Maintenance Dose: ☐ Inject SC two 150mg injections every other week. ☐ Inject SC two 150mg injections every four weeks. Consideration if body weight is below 100 kg, and completed 16 weeks of treatment.	Quantity:_____ Refills: _____
☐ Amjevita™ (adalimumab-atto)	☐ 40mg/0.8 mL Prefilled Syringe (citrate-free) ☐ 40mg/0.8 mL Prefilled SureClick® autoinjector (citrate-free) ☐ Other _____	☐ Psoriasis Induction Dose: Inject 80mg SC on day 1, followed by 40mg SC on day 8, then 40mg every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29 ☐ Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. ☐ Other_____	Quantity:_____ Refills: _____
☐ Avsola® (infliximab-axxq)	100mg Vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity:_____ # of 100mg vial Refills: _____
☐ Bimzelx® (bimekizumab-bkzx)	☐ 160mg/1mL autoinjector ☐ 160mg/1mL prefilled syringe	☐ Induction: inject 320mg (2 x 160mg injections) subcutaneously at weeks 0, 4, 8, 12, and 16 ☐ Maintenance: inject 320mg (2 x 160mg injections) subcutaneously every 8 weeks ☐ Other: _____	Quantity:_____ Refills: _____

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☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
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☐ L40.59 Other psoriatic arthropathy
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☐ L40.8 Other psoriasis _____
☐ Other Diagnosis: ICD-10 Code _____ Description _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Cibinqo™ (abrocitinib)	☐ 50mg tablet ☐ 100mg tablet ☐ 200mg tablet	☐ Take 100mg PO once daily ☐ Other: _____	Quantity: _____ Refills: _____
☐ Cimzia® (certolizumab pegol)	Cimzia Starter Kit (6 prefilled syringes)	☐ Loading Dose: Inject 400mg SC (2 prefilled syringes) initially and at weeks 2 and 4.	Quantity: 1 Kit Refills: 0
☐ Cimzia® (certolizumab pegol)	☐ 200mg/1 mL Prefilled Syringe ☐ 200mg Vial	Psoriasis Maintenance Dose: ☐ 400mg (given as 2 SC of 200mg each) every other week. ☐ 200mg SC every other week. Psoriatic Arthritis Maintenance Dose: ☐ 200mg SC every other week. ☐ 400mg (given as 2 SC of 200mg each) every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Cosentyx® (secukinumab)	☐ Sensoready® pen 150mg/mL injection ☐ Prefilled syringe 150mg/mL injection ☐ UnoReady pen 300mg/2mL injection	☐ Loading Dose: Inject 300mg SC at weeks 0, 1, 2, 3 and 4 (0 refills). ☐ Maintenance Dose: Inject 300mg SC every 4 weeks. ☐ Psoriatic Arthritis Loading Dose: (if needed): 150mg SC at weeks 0,1,2,3, and 4 (0 refills). ☐ Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Cyltezo® (adalimumab-adbm)	☐ 40mg/0.8mL Pen Psoriasis Starter Pack (4 pens) ☐ 40mg/0.8mL Pen Hidradenitis Suppurativa Starter Pack (6 pens) ☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL prefilled syringe	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: _____ Refills: _____

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☐ Other Diagnosis: ICD-10 Code _____ Description _____

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Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Dupixent® (dupilumab)	☐ 300mg/2ml Prefilled Pen ☐ 300mg/2mL Prefilled Syringe ☐ 200mg/1.14mL Prefilled Syringe	Adults with Atopic Dermatitis or Prurigo Nodularis: ☐ 600mg (two 300mg injections) followed by 300mg Q2W Pediatric Patients with Atopic Dermatitis: **Body Weight** / **Initial Dose** / **Subsequent Doses** ☐ 15 to less than 30 kg — 600mg (two 300mg injections) — 300mg Q4W ☐ 30 to less than 60 kg — 400mg (two 200mg injections) — 200mg Q2W ☐ 60 kg or more — 600mg (two 300mg injections) — 300mg Q2W	Quantity: _____ Refills: _____
☐ Enbrel® (etanercept)	☐ 50mg/mL Sureclick™ Autoinjector ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). Avella/Briova does not order the autoinjector. ☐ 25mg/0.5 mL Prefilled Syringe ☐ 25mg/0.5ml single-dose vial	☐ Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing (8 pens, 2 refills). ☐ Psoriasis Maintenance Dose: Inject 50mg SC ONCE a week. ☐ Psoriatic Arthritis Dose: Inject 50mg SC ONCE a week. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Hadlima™ (adalimumab-bwwd)	☐ 40mg/0.4ml prefilled syringe ☐ 40mg/0.8ml prefilled syringe ☐ 40mg/0.4ml PushTouch auto-injector ☐ 40mg/0.8ml PushTouch auto-injector	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: _____ Refills: _____
☐ Hulio® (adalimumab-fkjp)	☐ 20mg/0.4mL prefilled syringe ☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL pen	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: _____ Refills: _____

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NPI _____

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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

☐ L40.0 Psoriasis vulgaris
☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis _____
☐ Other Diagnosis: ICD-10 Code _____

Description _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Humira® (adalimumab)	☐ Psoriasis 80mg/0.8 mL and 40mg/0.4 mL Starter Package **Citrate Free**	☐ Psoriasis Induction Dose: Inject 80mg SC on day 1, followed by 40mg SC on day 8, then 40mg every other week.	Quantity: 1 Package Refills: 0
☐ Humira® (adalimumab)	☐ Hidradenitis Suppurativa 80mg/0.8 mL Starter Package **Citrate Free**	☐ Hidradenitis Suppurativa Induction Dose: Inject 160mg SC on Day 1, followed by 80mg two weeks later (Day 15), then 40mg every week starting on Day 29. ☐ Hidradenitis Suppurativa Induction Dose: Inject 160mg SC on Day 1, followed by 80mg two weeks later (Day 15), then 80mg every other week starting on Day 29.	Quantity: 1 Package Refills: 0
☐ Humira® (adalimumab)	☐ 40mg/0.4 mL Pen **Citrate Free** ☐ 40mg/0.4 mL Prefilled Syringe **Citrate Free** ☐ 80mg/0.8 mL Pen **Citrate Free** ☐ Other: _____	☐ Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. ☐ Hidradenitis Suppurativa Maintenance Dose: Inject 40mg SC every week. ☐ Hidradenitis Suppurativa Maintenance Dose: Inject 80mg SC every other week ☐ Other: _____	Quantity:_____ Refills: _____
☐ Hyrimoz® (adalimumab-adaz)	☐ 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit ☐ 40mg/0.4mL Sensoready Pen ☐ 80mg/0.8mL Sensoready Pen ☐ 40mg/0.4mL prefilled syringe	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity:_____ Refills: _____
☐ Idacio® (adalimumab-aacf)	☐ 40mg/0.8mL Prefilled Pen Plaque Psoriasis Starter Pack ☐ 40mg/0.8ml Prefilled Pen ☐ 40mg/0.8ml prefilled syringe	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week	Quantity:_____ Refills: _____
☐ Ilumya® (tildrakizumab-asmn)	100mg/mL Prefilled Syringe	☐ Psoriasis Induction Dose: Inject one pre-filled syringe (100mg) SC at weeks 0 and 4, then maintenance dosing (2 syringes, no refills). ☐ Psoriasis Maintenance Dose: Inject one pre-filled syringe (100mg) SC every 12 weeks. ☐ Other: _____	Quantity:_____ Refills: _____

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Description _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

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Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

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Medication	Strength	Dose & Directions	Qty/Refills
☐ Inflectra® (infliximab-dyyb)	100mg vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ Maintenance Dose: Infuse at 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity:_____ # of 100mg vial Refills: _____
☐ Litfulo (ritlecitinib)	50mg capsule	Take 50mg by mouth one time daily	Quantity:_____ Refills: _____
☐ Olumiant (baricitinib)	☐ 1mg tablet ☐ 2mg tablet ☐ 4mg tablet	Take 2mg by mouth one time daily. ☐ Other: _____	Quantity:_____ Refills: _____
☐ Orencia® (abatacept)	☐ 125mg/mL Prefilled Syringe ☐ 125mg/ml ClickJect Autoinjector ☐ 250mg vial ☐ Other: _____	Inject 125mg SC once weekly. ☐ Other: _____	Quantity:_____ Refills: _____
☐ Otezla® (apremilast)	Titration Starter Pack	Day 1: 10mg PO in the morning. Day 2: 10mg PO in the morning and 10mg PO in the evening. Day 3: 10mg PO in the morning and 20mg PO in the evening. Day 4: 20mg PO in the morning and 20mg PO in the evening. Day 5: 20mg PO in the morning and 30mg PO in the evening. Day 6 and thereafter: 30mg PO twice daily.	Quantity: 1 Pack Refills: 0
☐ Otezla® (apremilast)	30mg tablet	☐ Maintenance Dose: 30mg tablet PO twice daily. ☐ Other: _____	Quantity:_____ Refills: _____
☐ Remicade® (infliximab)	100mg Vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity:_____ # of 100mg vial Refills: _____

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Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Renflexis® (infliximab-abda)	100mg Vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100mg vial Refills: _____
☐ Rinvoq® (upadacitinib)	☐ 15mg tablet-Maintenance Dose ☐ 30mg table-Maintenance Dose	☐ Maintenance Dose: Take 15mg PO once daily ☐ Alternative Maintenance Dose: Take 30mg PO once daily	Quantity: _____ Refills: _____
☐ Siliq® (brodalumab)	☐ 210mg/1.5 mL single-dose prefilled syringe	Inject one prefilled syringe (210mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)	Quantity: _____ Refills: _____
☐ Simlandi® (adalimumab-ryvk)	40 mg/0.4mL auto-injector	☐ Psoriasis Initiation: Inject 80 mg SQ on Day 1, then 40 mg on Day 8, then 40 mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40 mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80 mg SQ on Day 15 ☐ HS maintenance: 40 mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80 mg QV every other week starting on Day 29	Quantity: _____ Refills: _____
☐ Simponi® (golimumab)	☐ 50mg/0.5 mL SmartJect® Autoinjector ☐ 50mg/0.5 mL Prefilled Syringe	☐ Psoriatic Arthritis Dose: Inject 50mg SC once a month. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi Aria® (golimumab)	50mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: ☐ Induction Dose: 2mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: 2mg/kg IV infusion over 30 minutes every 8 weeks.	Quantity: _____ # of 50mg vial Refills: _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. 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: _____

Dispense as Written	**Substitution Permitted**
Prescriber's Signature _____ Date _____ Electronic or digital signatures not accepted.	Prescriber's Signature _____ Date _____ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) _____

Optum

Dermatology Enrollment Form

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

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy - tear here

This form is not a valid prescription in Arizona or Virginia

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____

Address _____

Address 2 _____

City, State, Zip _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

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

☐ L40.0 Psoriasis vulgaris
☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis _____
☐ Other Diagnosis: ICD-10 Code _____

Description _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

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Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Skyrizi® (risankizumab-rzaa)	☐ 150mg/mL prefilled syringe ☐ 150mg/mL prefilled pen	☐ Psoriasis Induction Dose: Inject 150mg SC at Weeks 0 and 4, then maintenance dosing (0 refills). ☐ Psoriasis Maintenance Dose: Inject 150mg SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Sotyktu® (deucravacitinib)	6mg tablet	☐ Take one 6mg tablet PO once daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Stelara® (ustekinumab)	☐ 45mg/0.5 mL prefilled syringe ☐ 90mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45mg SC initially and 4 weeks later (2 syringes, 0 refills). ☐ For patients weighing >100 kg (220 lbs): Inject 90mg 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: _____
☐ Taltz® (ixekizumab)	☐ 80mg Single Dose Autoinjector ☐ 80mg Single Dose Prefilled Syringe	Psoriasis Induction Dosing: ☐ Starting Dose: Inject SC two 80mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80mg injection every 2 weeks (weeks 2-10). ☐ Final Induction Dose: Inject SC one 80mg injection (week 12). Psoriatic Arthritis Induction Dosing: ☐ Induction Dose: 160mg SC at week 0.	☐ 8 pens/syringes ☐ 2 pens/syringes
		☐ Maintenance Dose: 80mg SC once every 4 weeks.	Quantity: _____ Refills: _____

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DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

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Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

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☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis _____
☐ Other Diagnosis: ICD-10 Code _____

Description _____

Date of Diagnosis _____

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Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

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Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Tremfya® (guselkumab)	☐ 100mg/mL prefilled syringe ☐ 100mg/ml One-Press Injector	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills). ☐ Maintenance Dose: Inject 100mg SC once every 8 weeks.	Quantity: _____ Refills: _____
☐ Xeljanz® (tofacitinib)	☐ 5mg Tablet ☐ 11mg XR Tablet	☐ Take one 5mg tablet PO twice daily. ☐ Take one 11mg tablet PO once daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Yuflyma™ (adalimumab-aaty)	☐ 40mg/0.4mL prefilled syringe ☐ 40mg/0.4mL autoinjector	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: _____ Refills: _____
☐ Yusimry™ (adalimumab-aqvh)	☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL auto-injector	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: _____ Refills: _____
☐ Other	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

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