Kohll's RX SPECIALTY CARE

PSORIASIS SPECIALTY CARE PROGRAM

Phone: **877-324-2501** • Fax: **888-972-4110**

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:

❍ To Be Administered by Pharmacist ❍ 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	❑ Inject 400mg SC every other week ❑ **Induction Dose:** (Weight <90kg) Inject 400mg SC every other week initially and at weeks 2 and 4 ❑ **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 ❑ **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	5 10 1 2	0 0
❑ ENBREL®	❑ 50mg/ml Sureclick Autoinjector ❑ 50mg/ml 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 ❑ > 138lbs or more: Inject 50mg weekly ❑ < 138lbs: Inject 0.8mg/kg weekly ❑ Other: _____	8 4 4	2
❑ HUMIRA®	❑ Psoriasis Starter Package ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ Hidradenitis Suppurativa Starter Package ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe *All strengths and dosages listed are Humira® Citrate Free*	❑ **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: _____ ❑ **Induction Dose:** ❑ 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 ❑ **Maintenance:** Inject 40mg SC on day 29 and every week thereafter ❑ *Patient has signed HUMIRA Complete form*	 2 4	0 0
❑ ORENCIA®	❑ 125mg/ml ClickJect™ Autoinjector ❑ 125mg/ml Prefilled Syringe	❑ Inject 125mg SC once a week	4	
❑ 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	1 60	0
❑ _____	_____	_____		

Rasuvo®, Simponi®, Stelara®, Taltz®, Tremfya™, Xeljanz® and Xeljanz® 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.

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