Kohll's Pharmacy & Homecare 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
❑ RASUVO®	❑ _____	❑ _____		
❑ SIMPONI® (for PsA)	❑ 50mg/0.5ml Smartject Injector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month	1	
❑ STELARA®	❑ 45mg/ml Single-Dose Vial	❑ **Induction Dose:** To achieve pediatric dose:		
		❑ < 60kg: Inject 0.75mg/kg		0
		❑ 60kg - 100kg: Inject 45mg SC	1	0
		❑ > 100kg: Inject 90mg SC	1	0
	❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs)	❑ Inject the contents of 1 prefilled syringe SC on day 1		
	❑ 90mg/1ml Prefilled Syringe (for > 220 lbs)	❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter	1	
	❑ Yes or ❑ No: ***STELARA SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ TALTZ®	❑ 80mg/ml Single-Dose Prefilled Autoinjector ❑ 80mg/ml Single-Dose Prefilled Syringe	❑ **Induction Dose:** Inject 160mg SC (two 80mg injections) at weeks 0 then 80mg SC at weeks 2, 4, 6, 8, 10 and 12	8	0
		❑ **Maintenance:** Inject 80mg subcutaneously every 4 weeks	1	
❑ TREMFYA™	❑ 100mg/ml Prefilled Syringe	❑ **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	
❑ _____	_____	_____		

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**

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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