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 a Healthcare Provider ❍ 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	
❑ SKYRIZI™	❑ 75mg/0.83ml Prefilled Syringe	❑ **Induction Dose:** Inject 150mg (two 75mg injections) SC at weeks 0 and 4	4	0
		❑ **Maintenance:** Inject 150mg (two 75mg injections) SC every 12 weeks thereafter	2	
	❑ Yes or ❑ No: ***SKYRIZI SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ 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	❑ **Weeks 0-2:** Inject 160mg SC (two 80mg injections) at weeks 0, then inject 80mg SC at week 2	3	0
		❑ **Weeks 4-10:** Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	2	1
		❑ **Week 12 and onwards:** lInject 80mg SC at week 12 and every 4 weeks thereafter	1	
❑ TREMFYA™	❑ 100mg/ml Prefilled Syringe ❑ 100mg/ml One- Press Patient Controlled Injector	❑ **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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