PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

❶ PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

❸ 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: _____
❑ ISGA or ❑ EASI _____

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B and Hep C 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:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	
❑ Biologics	
❑ Corticosteroids	
❑ Immunosuppressants	
❑ Methotrexate	
❑ NSAIDS	
❑ Surgery	
❑ Topical/Oral Antibiotics	
❑ UVA ❑ UVB	
❑ Others	

❹ INJECTION TRAINING:
❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ To be Administered by a Healthcare Provider ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY:
❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ 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
❑ COSENTYX®	❑ 150mg/ml single-dose Sensoready® Pen ❑ 150mg/ml single-dose Prefilled Syringe ❑ 75mg/0.5ml solution in a single-dose Prefilled Syringe ❑ For Healthcare Professional Use Only: 150mg lyophilized powder in a single-dose vial for reconstitution	**PsO pediatric patients 6 years and older:** ❑ <50kg: 75mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter ❑ ≥50kg: 150mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter **PsA pediatric patients 2 years and older:** ❑ ≥15kg and <50kg: 75mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter ❑ ≥50kg: 150mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter **Enthesitis-Related Arthritis 4 years and older:** ❑ ≥15kg and <50kg: 75mg at weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter ❑ ≥50kg: 150mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter		
❑ DUPIXENT®	**Pediatric Atopic Dermatitis (6 months to 17 years of age):** ❑ 300mg/2ml single-dose Prefilled Syringe ❑ 200mg/1.14ml single-dose Prefilled Syringe ❑ 300mg/2ml single-dose Prefilled Pen ❑ 200mg/1.14ml single-dose Prefilled Pen	❑ **Induction Dose:** ❑ **≥60kg:** Inject 600mg SC (two 300mg injections) ❑ **30 to <60kg:** Inject 400mg SC (two 200mg injections) ❑ **15 to <30kg:** Inject 600mg SC (two 300mg injections) ❑ **Maintenance Dose:** ❑ **≥60kg:** Inject 300mg SC every other week ❑ **30 to <60kg:** Inject 200mg SC every other week ❑ **15 to <30kg:** Inject 300mg SC every 4 weeks ❑ **Pediatric patients 6 months to 5 years of age:** ❑ 5 to<15kg: 200mg (one 200mg injection) every 4 weeks ❑ 15 to<30kg: 300mg (one 300mg injection) every 4 weeks	2	0
❑ EUCRISA®	**Pediatric patients 3 months of age and older:** ❑ 2% Ointment	❑ Apply a thin layer twice daily on affected area	60g 100g	0
❑ ENBREL®	❑ 50mg/ml Sureclick® Autoinjector ❑ 50mg/ml Enbrel Min® Prefilled Cartridge For Enbrel Mini® only: AutoTouch® reusable Autoinjector ❑ 50mg/ml Prefilled Syringe ❑ 25mg/0.5ml Prefilled Syringe ❑ 25mg Lyophilized Power Vial ❑ Other: _____	**Plaque Psoriasis + Polyarticular Juvenile Idiopathic Arthritis Weight-Based Dosing** ❑ > 63 kg or more: Inject 50mg weekly ❑ < 63 kg: Inject 0.8mg/kg weekly (maximum 50mg/week) (To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder)		
❑ HUMIRA®	**Hidradenitis Suppurativa** ❑ Adolescent Hidradenitis Suppurativa 80mg/0.8ml and 40mg/0.4ml Starter pack ❑ Adolescent Hidradenitis Suppurativa 40mg/0.4ml Starter Package ❑ Adolescent Hidradenitis Suppurativa 40mg/0.8ml Starter Package ❑ 40mg/0.4ml Pen ❑ 40mg/0.8ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe	❑ **Induction Dose (Adolescents 12 years and older):** ❑ **30kg to <60kg:** Inject 80mg SC on day 1, then 40mg SC on day 8 and every other week thereafter ❑ **≥60kg:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ❑ **≥60kg:** Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 ❑ **Maintenance Dose (Adolescents 12 years and older):** ❑ **30kg to <60kg:** Inject 40mg every other week ❑ **≥60kg:** Inject 40mg on day 29 then Inject 40mg every week ❑ **≥60kg:** Inject 80mg on day 29 then Inject 80mg every other week		
❑ _____	_____	_____		

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.

v10.2_093022

PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

❶ PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

❸ 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: _____
❑ ISGA or ❑ EASI _____

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B and Hep C 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:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	
❑ Biologics	
❑ Corticosteroids	
❑ Immunosuppressants	
❑ Methotrexate	
❑ NSAIDS	
❑ Surgery	
❑ Topical/Oral Antibiotics	
❑ UVA ❑ UVB	
❑ Others	

❹ INJECTION TRAINING:
❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ To be Administered by a Healthcare Provider ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY:
❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ 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
❑ HUMIRA®	**Juvenile Idiopathic Arthritis + Pediatric Uveitis** ❑ 10mg/0.1ml Prefilled Syringe ❑ 10mg/0.2ml Prefilled Syringe ❑ 20mg/0.2ml Prefilled Syringe ❑ 20mg/0.4ml Prefilled Syringe ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 40mg/0.8ml Pen	❑ **Weight-Based Dosing (5 years and older):** ❑ **10kg to <15kg:** Inject 10mg SC every other week ❑ **15kg to <30kg:** Inject 20mg SC every other week ❑ **≥30kg:** Inject 40mg SC every other week		
❑ HUMIRA®	**Pediatric Crohn's Disease** ❑ **Pediatric Crohn's Starter Pack Prefilled Syringe:** ❑ 80mg/0.8ml, 40mg/0.4ml ❑ 40mg/0.8ml ❑ 80mg/0.8ml ❑ **Maintenance pack** ❑ 20mg/0.2ml Prefilled Syringe ❑ 20mg/0.4ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe *All strengths and dosages listed are Humira® Citrate Free*	❑ **Induction Dose (Pediatrics patients 6 years and older):** ❑ **17kg to <40kg:** Inject one 80mg pen SC on day 1, then one 40mg pen SC on day 15 ❑ **≥40kg:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ❑ **≥40kg:** Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 ❑ **Maintenance Dose (Pediatrics patients 6 years and older):** ❑ **17kg to <40kg:** Inject 20mg SC every other week ❑ **≥40kg:** Inject 40mg SC every other week	2 3 2	0 0
❑ HUMIRA®	**Pediatric Ulcerative Colitis** ❑ Pediatric Ulcerative Colitis' Starter Pack: 80mg/0.8ml Pen ❑ 20mg/0.2ml Prefilled Syringe ❑ 20mg/0.4ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 40mg/0.8ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe	❑ **Induction Dose (5 years and older):** ❑ **20kg to 40kg:** Inject 80mg SC at week 0 (day 1), then 40mg SC at week 1 (day 8), then 40mg SC at week 2 (day 15) ❑ **>40kg:** Inject 160mg SC at week 0 (day 1), then 80mg SC at week 1 (day 8), then 40mg SC at week 2 (day 15) ❑ **Maintenance Dose (Pediatric patients 5 years and older):** ❑ **20kg to 40kg:** Inject 40mg SC at week 4 (day 29) and every other week thereafter ❑ **20kg to 40kg:** Inject 20mg SC at week 4 (day 29) and every other week thereafter ❑ **40kg:** Inject 80mg SC at week 4 (day 29) and every other week thereafter ❑ **40kg:** Inject 40mg SC at week 4 (day 29) and every other week thereafter		
❑ OPZELURA™	**12 years of age and older:** ❑ 1.5% Cream	❑ Apply a thin layer twice daily to affected areas *Do not use more than 60 grams per week*	60g	
❑ _____	_____	_____		

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: _____

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Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

❸ 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: _____
❑ ISGA or ❑ EASI _____

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B and Hep C ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No

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❑ Corticosteroids	
❑ Immunosuppressants	
❑ Methotrexate	
❑ NSAIDS	
❑ Surgery	
❑ Topical/Oral Antibiotics	
❑ UVA ❑ UVB	
❑ Others	

❹ INJECTION TRAINING:
❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ To be Administered by a Healthcare Provider ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY:
❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ 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
❑ RINVOQ® XR	❑ 15mg ER Tablet ❑ 30mg ER Tablet	❑ **Pediatric patients 12 years of age and older weighing at least 40kg:** ❑ Take 15mg tablet once daily **"If an adequate response is not achieved, consider increasing the dosage to 30mg orally once daily"**	30	
❑ STELARA®	❑ 45mg/0.5ml Prefilled Syringe ❑ 45mg/0.5ml Single-Dose Vial ❑ 90mg/ml Prefilled Syringe	**Psoriasis Pediatric Dose (6 to 17 years old):** ❑ < 60kg: Inject Inject 0.75 mg/kg SC initially at 4 weeks, then every 12 weeks thereafter ❑ 60kg - 100kg: Inject 45mg SC initially at 4 weeks, then every 12 weeks thereafter ❑ > 100kg: Inject 90 mg SC initially at 4 weeks, then every 12 weeks thereafter	 1 	0 0 0
		Psoriatic Arthritis Pediatric Dose (6 to 17 years old): ❑ < 60kg: Inject Inject 0.75 mg/kg SC initially at 4 weeks, then every 12 weeks thereafter ❑ > 60kg: Inject 45mg SC initially at 4 weeks, then every 12 weeks thereafter ❑ > 100kg with co-existent moderate-to-severe plaque psoriasis: Inject 90 mg SC initially at 4 weeks, then every 12 weeks thereafter		
❑ TALTZ®	**Pediatric Plaque Psoriasis** ❑ 80mg/ml Single-Dose Prefilled Autoinjector ❑ 80mg/ml Single-Dose Prefilled Syringe	❑ **Induction Dose (6 years and older):** ❑ >50kg: Inject 160mg SC (two 80mg injections) at week 0 ❑ 25 to 50kg: Inject 80 mg SC at week 0 ❑ <25kg: Inject 40mg SC at week 0	2 1	0
		❑ **Maintenance Dose (6 years and older):** ❑ **>50kg:** Inject 80mg SC at week 4 and every 4 weeks thereafter ❑ **25 to 50kg:** Inject 40 mg SC at week 4 and every 4 weeks thereafter ❑ **<25kg:** Inject 20 mg at week 4 and every 4 weeks thereafter		
	20 mg and 40 mg doses for patients weighing ≤50 kg (110 lb) must be prepared and administered by a qualified healthcare professional.			
❑ XELJANZ®	**Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)** ❑ 1mg/ml oral solution	❑ **Weight-Based Dosing** ❑ **Pediatric patients 2 years and older 10kg to < 20kg:** Take 3.2 mg (3.2 ml oral solution) twice daily ❑ **Pediatric patients 2 years and older 20kg to < 40kg:** Take 4 mg (4 ml oral solution) twice daily ❑ **Pediatric patients 2 years and older ≥ 40kg:** Take 5 mg (one 5 mg oral tablet or 5 mL oral solution) twice daily	60	
	❑ 5mg tablets	❑ Take 5 mg by mouth twice daily		
❑ YUSIMRY™	**Juvenile Idiopathic Arthritis + Pediatric Crohn's Disease** ❑ 40mg/0.8ml Prefilled Syringe	**Juvenile idiopathic arthritis pediatric patients 2 years of age and older >30kg:** ❑ Inject 40 mg SC every other week		
		CD pediatric patients 6 years of age and older >40kg: ❑ **Induction Dose:** Inject 160mg SC on day 1 and 80mg on day 15 ❑ **Maintenance Dose:** Inject 40mg SC every other week (Starting on Day 29)		
❑ _____	_____	_____		

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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