PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

v10.2_093022

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PATIENT IN	FORMATION:			R INFORMATION:			
			Address:				
Citv:	State:	Zip:	Citv:	State: Zip	:		
	Alt. Phone:			Fax:			
				DEA:			
	Gender: O M O F Care						
Height: \	Neight: Allergies	S:		Phone:			
STATEMEN1	OF MEDICAL NECE	SSITY: (Please Atta	ch All Medical Documentation)	Prior Failed Indicat	e Drug N	lame	
Date of Diagnosis:		Patient also taking M	lethotrexate? □ Yes □ No	Treatments: and Leng			
ICD-10:	Other:	Serious or active infe		□ 5-ASA □ Biologics			
	Negative Date:	Hep B and Hep C rul		□ Corticosteroids			
	ST: Date:	treatment started? Does patient have lat	□ Yes □ No tex allergy? □ Yes □ No	Immunosuppressants			
Assessment: U Moder % BSA affected	rate Mod to Severe Severe		on is denied, recommended	Methotrexate MSAIDS			
	nest 🗆 Arms 🗆 Hands 🗖 Nails		ives will be provided to the	□ Surgery			
•	uttocks 🗆 Legs 🗅 Other:	prescriber based u	pon the patient's insurance	□ Topical/Oral Antibiotics			
□ ISGA or □ EASI	-	coverage.		□ Others			
	RAINING: O Pharmacist to P	rovide Training ${\mathbf O}$ Patien	nt Trained in MD Office $ {f O} $ To be Admi	nistered by a Healthcare Provider $ { m O} $ Manufac	turer Nurse	e Support	
	DELIVERY: O Patient's	-		-			
	INFORMATION: Plea	se Include Front	and Back Copies of Phar	rmacy and Medical Card			
PRESCRIPTION	INFORMATION: (Ple	ase be sure to cl	hoose both induction and	d maintenance dose where ap	plicabl	le)	
Patient Name:			Patient	's Date of Birth:			
Medication	Dosage & Strength			ction	QTY	Refills	
	······································		PsO pediatric patients 6 years an \square <50kg: 75mg at week 0, 1, 2, 3, and 4 \square ≥50kg: 150mg at week 0, 1, 2, 3, and	and every 4 weeks thereafter			
_	 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 		PsA pediatric patients 2 years an	and older:			
			 ➡ ≥15kg and <50kg: 75mg at week 0, 1, 2 ➡ ≥50kg: 150mg at week 0, 1, 2, 3, and 	2, 3, and 4 and every 4 weeks thereafter 4 and every 4 weeks thereafter			
			Enthesitis-Related Arthritis 4 yea	rs and older:			
			□ ≥50kg: 150mg at week 0, 1, 2, 3, and	and 4 and every 4 weeks thereafter			
				injections)			
	YX® 175mg/0.5ml solution in a single-dose Prefilled Syringe For Healthcare Professional Use Only: 150mg ≥50kg: 150mg 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 ≥50kg: 150mg 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 ≥50kg: 150mg 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 ≥50kg: 150mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter >≥15kg and <50kg: 75mg at week 0, 1, 2, 3, and 4 and every 4 weeks thereafter	2	0				
	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		Maintenance Dose:		++		
			□ ≥60kg: Inject 300mg SC every other v □ 30 to <60kg: Inject 200mg SC every of	other week			
			 I5 to <30kg: Inject 300mg SC every Pediatric patients 6 months to 				
			□ 5 to<15kg: 200mg (one 200mg injecti □ 15 to<30kg: 300mg (one 300mg injection)	on) every 4 weeks			
	Pediatric patients 3 months of ag	e and older:	Apply a thin layer twice daily on affect		60g 100g	0	
	50ma/ml Sureclick [®] Autoiniector		Plaque Psoriasis + Polyarticular	Iuvanila Idianathia Arthritia	1009		
	50mg/ml Enbrel Min [®] Prefilled Cartridge For		Weight-Based Dosing				
	□ 50mg/ml Prefilled Syringe □ 25mg/0.5ml Prefilled Syringe	le Automjector	\square > 63 kg or more: Inject 50mg weekly \square < 63 kg: Inject 0.8mg/kg weekly (max				
	25mg/0.5mm Preniled Syndge 25mg Lyophilized Power Vial Other:		(To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder)				
	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/0.8ml Pen 40mg/0.8ml Pen 80mg/0.8ml Pen		Induction Dose (Adolescents 1	12 years and older):	+		
			□ 30kg to <60kg: Inject 80mg SC on day 1, then 40mg SC on day 8 and				
			$R \square > 60 kg$; Inject two 80 mg pers SC on day 1, then one 80 mg per 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				
	40mg/0.8ml Prefilled Syringe		■ ≥60kg: Inject 40mg on day 29 then In ■ ≥60kg: Inject 80mg on day 29 then In	ject 40mg every week			
	80mg/0.8ml Prefilled Syringe			JOOL COTTY OVER WEEK	+		
			on for initiating and coordinating insurance	prior authorizations, nursing services and patient as	- I	ograme	
Signature:		armacy to act as my designe	Signature	prior authorizations, nursing services and patient as		ogranis.	
	Substitution Permitted		-	Dispense As Written			
Prior authorization approval and insura	ance benefits will be determined by the payor based upor	the patient's eligibility, medical neces	ssity, and the terms of the patient's coverage, among oth	her things. Participation in this program is not a guarantee of prior a	uthorization or o	of payment.	

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PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

PATIENT INFO Name:					R INFORMATION:		
City:	State:	Zip:	City:		State: Zip:		
	Alt. Phone:				Fax:		
Email:			NPI:		DEA:		
DOB: Ge	ender: OM OF Care	giver:	Tax I.D.:				
Height: We	eight: Allergies	3:	Office C	ontact:	Phone:		
STATEMENT C	OF MEDICAL NECE	SSITY: (Please Attach A	Il Medical Docu	umentation)	Prior Failed Indicate		
Date of Diagnosis: Patient also taking Mether ICD-10: Other: Serious or active infection		otrexate?	🗆 Yes 🗖 No	Treatments: and Length		atment:	
				🛛 Yes 🖾 No	Biologics		
TB Test: Positive Ne	egative Date:	Hep B and Hep C ruled	out or		Corticosteroids		
	Date: Mod to Severe D Severe	treatment started? Does patient have latex	allerov?	□ Yes □ No □ Yes □ No	 Immunosuppressants Methotrexate 		
% BSA affected		If Prior Authorization i					
	t 🗆 Arms 🗆 Hands 🗖 Nails	formulary alternatives	,		Surgery Transact/Oral Antibiotics		
•	ocks 🗆 Legs 🖵 Other:	prescriber based upor	n the patient	's insurance	□ Topical/Oral Antibiotics		
□ ISGA or □ EASI		coverage.			Others		
	AINING: O Pharmacist to P	rovide Training $ {f O} $ Patient Tra	ined in MD Offic	ce ${f O}$ To be Admir	histered by a Healthcare Provider $ {f O}$ Manufactu	urer Nurse	Support
<u> </u>	LIVERY: O Patient's	-			-		
6 INSURANCE I	NFORMATION: Plea	se Include Front an	d Back Co	pies of Phar	macy and Medical Card		
	NFORMATION: (Ple	ase be sure to choo	ose both ii		d maintenance dose where ap	olicabl	le)
Patient Name:					s Date of Birth:		
Medication Do	sage & Strength			Directio	n	QTY	Refills
	Juvenile Idiopathic Arthritis 4 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/0.8ml Pen		10kg to <15kg 15kg to <30kg	ed Dosing (5 year : Inject 10mg SC eve : Inject 20mg SC eve 10mg SC every other	ery other week ery other week		
			Induction Dose (Pediatrics patients 6 years and older):			2	0
	Prefilled Syringe:		□ 17kg to <40kg: Inject one 80mg pen SC on day 1, then one 40mg pen SC on d □ ≥40kg: Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15				0
	 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 			one 80mg pen SC o pen SC on day 15	n day 1, then 80mg pen SC on day 2,	3	
☐ HUMIRA [®]			 □ Maintenance Dose (Pediatrics patients 6 years and older): □ 17kg to <40kg: Inject 20mg SC every other week □ ≥40kg: Inject 40mg SC every other week sted are Humira[®] Citrate Free 			2	
			o mannia	5.0.000 1.000		1	
	 Pediatric Ulcerative Colitis Pediatric Ulcerative Colitis' Starter Pack: 80mg/0.8ml Pen 20mg/0.2ml Prefilled Syringe 20mg/0.4ml Prefilled Syringe 		20kg to 40kg: then 40mg SC >40kg: Inject 1	at week 2 (day 15)	older): eek 0 (day 1), then 40mg SC at week 1 (day 8), (day 1), then 80mg SC at week 1 (day 8),		
	 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 		20kg to 40kg: 20kg to 40kg: 40kg: Inject 80	Inject 40mg SC at w Inject 20mg SC at w Img SC at week 4 (da	c patients 5 years and older): eek 4 (day 29) and every other week thereafter eek 4 (day 29) and every other week thereafter ay 29) and every other week thereafter ay 29) and every other week thereafter		
□ OPZELURA [™]	12 years of age and older:	C	Apply a thin I	ayer twice daily to	affected areas	60g	
□ 1.5% Cream		Do not use i	more than 60 grar	ns per week	30g		

PRESCRIBER SIGNATURE	I authorize pharmacy to act as my design	ee for initiating and coordinating insurance prior aut	norizations, nursing services and patient assistance programs.
Signature:	Date:	Signature:	Date:
Substitution Permit	tted	Dispe	nse As Written
Prior authorization approval and insurance benefits will be determined by	the payor based upon the patient's eligibility, medical nece	essity, and the terms of the patient's coverage, among other things. F	Participation in this program is not a guarantee of prior authorization or of payment

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PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

	INFORMATION:				R INFORMATION:			
City: Phone: Email:	State: Alt. Phone: Gender: O M O F Ca Weight: Allerg	Zip:	_ City: _ _ Phone: NPI:		State: _ Fax: DEA:	Zip:		
STATEMI Date of Diagnosis ICD-10: TB Test: □ Positir LFT: ALT: Assessment: □ M% BSA affe □ Scalp □ Face	ENT OF MEDICAL NEC	 Patient also taking Me Serious or active infec Hep B and Hep C ruled treatment started? Does patient have late If Prior Authorization formulary alternative 	All Medical Do thotrexate? tion present? d out or x allergy? n is denied, ro es will be pro	Cumentation) Yes No Yes No Yes No Yes No Yes No Yes No commended vided to the	Prior Failed	Indicate D and Length c	rug Na of Trea	ame itment:
-						O Manufacture	r Nurse	Support
-	T DELIVERY: O Patien					rd		
PRESCRIPT Patient Name: Medication	ION INFORMATION: (F Dosage & Strength	Please be sure to ch	oose both		s Date of Birth:			e) Refills
	[®] XR □ 15mg ER Tablet □ 30mg ER Tablet	 Pediatric patients 12 y Take 15mg tablet once "If an adequate response 	daily		least 40kg: asing the dosage to 30mg orall	y once daily"	30	
	45mg/0.5ml Prefilled Syringe	Psoriasis Pediatric Dos □ < 60kg: Inject Inject 0.7	5 mg/kg SC initiang SC initiang SC initially at	ally at 4 weeks, then 4 weeks, then every	12 weeks thereafter	-	1	0 0 0
□ STELARA®	A [®] □ 45mg/0.5ml Single-Dose Vial □ 90mg/ml Prefilled Syringe	Psoriatic Arthritis Pedia □ < 60kg: Inject Inject 0.73 □ > 60kg: Inject 45mg SC □ > 100kg with co-existen	5 mg/kg SC initia initially at 4 wee	ally at 4 weeks, then ks, then every 12 we	eks thereafter			

Inject 90 mg SC initially at 4 weeks, then every 12 weeks thereafter

□ >50kg: Inject 80mg SC at week 4 and every 4 weeks thereafter

 $\label{eq:starsest} \begin{array}{|c|c|c|c|c|} \hline 25 to $50kg$: Inject 40 mg SC at week 4 and every 4 weeks thereafter \\ \hline $<25kg$: Inject 20 mg at week 4 and every 4 weeks thereafter \\ \hline \end{tabular}$

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 ≥ 40kg: Take 5 mg (one 5 mg oral tablet or 5 mL oral solution) twice daily

Dispense As Written

Pediatric patients 2 years and older 20kg to < 40kg: Take 4 mg (4 ml oral solution) twice daily

Juvenile idiopathic arthritis pediatric patients 2 years of age and older >30kg:

Signature:

□ >50kg: Inject 160mg SC (two 80mg injections) at week 0

2

1

60

Date:

0

□ Induction Dose (6 years and older):

□ 25 to 50kg: Inject 80 mg SC at week 0

□ Maintenance Dose (6 years and older):

20 mg and 40 mg doses for patients weighing ≤50 kg (110 lb) must be prepared and administered by a qualified healthcare professional.

<25kg: Inject 40mg SC at week 0</p>

Weight-Based Dosing

Date:

Take 5 mg by mouth twice daily

Inject 40 mg SC every other week

Pediatric Plaque Psoriasis

□ 80mg/ml Single-Dose Prefilled

□ 80mg/ml Single-Dose Prefilled

Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)

Juvenile Idiopathic Arthritis +

Pediatric Crohn's Disease 40mg/0.8ml Prefilled Syringe

Substitution Permitted

□ 1mg/ml oral solution

5mg tablets

Autoiniector

Syringe

XELJANZ[®]

□ YUSIMRY[™]

Signature:

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PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

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)