Cosentino's SPECIALTY CARE

PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

Phone: **833-796-6470** • Fax: **844-841-3401**

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: _____
❑ 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	

4 INJECTION TRAINING:

❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ To be Administered by a Healthcare Provider ❍ 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
❑ COSENTYX®	**Pediatric Plaque Psoriasis** ❑ 75 mg/0.5 mL single-dose prefilled syringe ❑ 150 mg/ mL single-dose Sensoready prefilled syringe ❑ 150 mg/ mL single-dose Sensoready prefilled pen ❑ For Healthcare Professional Use Only: 150 mg lyophilized powder in a single-dose vial for reconstitution	**Induction Dose:** ❑ Pediatric patients 6 years and older <50kg: Inject 75 mg SC at weeks 0, 1, 2, 3, and 4 ❑ Pediatric patients 6 years and older ≥ 50kg: Inject 150 mg SC at weeks 0, 1, 2, 3, and 4 **Maintenance Dose:** ❑ Pediatric patients 6 years and older <50kg: Inject 75 mg SC every 4 weeks thereafter ❑ Pediatric patients 6 years and older ≥50kg: Inject 150 mg SC at 4 weeks thereafter		
❑ DUPIXENT®	**Pediatric Atopic Dermatitis** ❑ 300mg/2ml Prefilled Syringe ❑ 200mg/1.14ml Prefilled Syringe ❑ 300mg/2ml Prefilled Pen *(only for 12 years and older)*	❑ **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	2	0
❑ HUMIRA®	**Hidradenitis Suppurativa** ❑ Adolescent Hidradenitis Suppurativa 80mg/0.8ml and 40mg/0.4ml Starter pack ❑ Adolescent Hidradenitis Suppurativa 40mg/0.4ml Starter Package ❑ Hidradenitis Suppurativa: 80mg/0.8ml Starter pack ❑ Hidradenitis Suppurativa: 40mg/0.4ml Starter pack ❑ 40mg/0.4ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml 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 ❑ **Adolescents 12 years and older ≥60kg:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ❑ **Adolescents 12 years and older ≥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 ❑ **Adolescents 12 years and older ≥60kg:** Inject 40mg on day 29 then Inject 40mg every week ❑ **Adolescents 12 years and older ≥60kg:** Inject 80mg on day 29 then Inject 80mg every other week	3 4 3 6 2	0 0 0 0
❑ _____	_____	_____		

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

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Address: _____
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Phone: _____ Fax: _____
NPI: _____ DEA: _____
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Date of Diagnosis: _____
ICD-10: _____ Other: _____
TB Test: ❑ Positive ❑ Negative Date: _____
LFT: ALT: _____ AST: _____ Date: _____
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_____% 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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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 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to 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 ❑ 20mg/0.2ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe	❑ **Pediatrics patients 2 years and older 10kg to <15kg:** Inject 10mg SC every other week ❑ **Pediatrics patients 2 years and older 15kg to <30kg:** Inject 20mg SC every other week ❑ **Pediatrics patients 2 years and older ≥30kg:** Inject 40mg SC every other week	2	
❑ HUMIRA®	**Pediatric Crohn's Disease** ❑ Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml ❑ Pediatric Crohn's Starter Pack: 80mg/0.8ml ❑ 20mg/0.2ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe	❑ **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 ❑ **Pediatrics patients 6 years and older ≥40kg:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ❑ **Pediatrics patients 6 years and older ≥40kg:** Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15	2 3	0 0
		❑ **Maintenance Dose:** ❑ **Pediatrics patients 6 years and older 17kg to <40kg:** Inject 20mg SC every other week ❑ **Pediatrics patients 6 years and older ≥40kg:** Inject 40mg SC every other week	2	
	All strengths and dosages listed are Humira® Citrate Free			
❑ HUMIRA®	**Pediatric Ulcerative Colitis** ❑ Pediatric Ulcerative Colitis' Starter Pack: 80mg/0.8ml Pen ❑ 20mg/0.2ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 80mg/0.8ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Prefilled Syringe	❑ **Induction Dose:** ❑ **Pediatric patients 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) ❑ **Pediatric patients 5 years and older > 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 every other week at week 4 (day 29) thereafter ❑ **Pediatric patients 5 years and older 20kg to 40kg:** Inject 20mg SC every week at week 4 (day 29) thereafter ❑ **Pediatric patients 5 years and older > 40kg:** Inject 80mg SC every other week at week 4 (day 29) thereafter ❑ **Pediatric patients 5 years and older > 40kg:** Inject 40mg SC every week at week 4 (day 29) thereafter		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:

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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
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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 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to 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
❑ STELARA®	**Pediatric Plaque Psoriasis** ❑ 45mg/0.5ml Prefilled Syringe ❑ 45mg/0.5ml Single-Dose Vial ❑ 90mg/ml Prefilled Syringe	❑ **Induction Dose:** ❑ **Pediatric patients 6 years and older <60kg:** Inject 0.75mg/kg SC at Week 0 ❑ **Pediatric patients 6 years and older 60 – 100kg:** Inject 45mg SC at Week 0 ❑ **Pediatric patients 6 years and older >100kg:** Inject 90mg SC at Week 0	1 1	0 0 0
		❑ **Maintenance Dose:** ❑ **Pediatric patients 6 years and older <60kg:** Inject 0.75mg/kg SC at Week 4, then every 12 weeks thereafter ❑ **Pediatric patients 6 years and older 60 – 100kg:** Inject 45mg SC at Week 4, then every 12 weeks thereafter ❑ **Pediatric patients 6 years and older >100kg:** Inject 90mg SC at Week 4, then every 12 weeks thereafter		
❑ TALTZ®	**Pediatric Plaque Psoriasis** ❑ 80mg/ml Single-Dose Prefilled Autoinjector ❑ 80mg/ml Single-Dose Prefilled Syringe	❑ **Induction Dose:** ❑ **Pediatric patients 6 years and older <60kg:** Inject 160mg SC (two 80mg injections) at week 0 ❑ **Pediatric patients 6 years and older 25 to 50kg:** Inject 80 mg SC at week 0 ❑ **Pediatric patients 6 years and older <25kg:** Inject 40mg SC at week 0	2 1	0
		❑ **Maintenance Dose:** ❑ **Pediatric patients 6 years and older >50kg:** Inject 80mg SC at week 4 and every 4 weeks thereafter ❑ **Pediatric patients 6 years and older 25 to 50kg:** Inject 40 mg SC at week 4 and every 4 weeks thereafter ❑ **Pediatric patients 6 years and older <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 ❑ 5mg tablets	❑ **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	
		❑ Take 5 mg by mouth twice daily		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:

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Signature: _____ Date: _____ Signature: _____ Date: _____

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