



PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

Phone: **856-963-4742** • Fax: **856-541-8580**



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: _____ Patient also taking Methotrexate? Yes No
 ICD-10: _____ Other: _____ Serious or active infection present? Yes No
 TB Test: Positive Negative Date: _____ Hep B ruled out or treatment started? Yes No
 LFT: ALT: _____ AST: _____ Date: _____ Does patient have latex allergy? Yes No
 Assessment: Moderate Mod to Severe Severe
 _____% BSA affected
 Scalp Face Chest Arms Hands Nails
 Back Groin Buttocks Legs Other: _____
 ISGA or EASI _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:
 5-ASA
 Biologics
 Corticosteroids
 Immunosuppressants
 Methotrexate
 NSAIDS
 Surgery
 Topical/Oral Antibiotics
 UVA UVB
 Others _____

Indicate Drug Name and Length of Treatment:

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

5 PRODUCT DELIVERY: Patient's Home 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
<input type="checkbox"/> DUPIXENT®	Pediatric Atopic Dermatitis <input type="checkbox"/> 300mg/2ml Prefilled Syringe <input type="checkbox"/> 200mg/1.14ml Prefilled Syringe <input type="checkbox"/> 300mg/2ml Prefilled Pen <i>(only for 12 years and older)</i>	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> ≥60 kg: Inject 600mg SC (two 300mg injections) <input type="checkbox"/> 30 to <60 kg: Inject 400mg SC (two 200mg injections) <input type="checkbox"/> 15 to <30 kg: Inject 600mg SC (two 300mg injections) <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> ≥60 kg: Inject 300mg SC every other week <input type="checkbox"/> 30 to <60 kg: Inject 200mg SC every other week <input type="checkbox"/> 15 to <30 kg: Inject 300mg SC every 4 weeks	2	0
<input type="checkbox"/> HUMIRA®	Hidradenitis Suppurativa <input type="checkbox"/> Adolescent Hidradenitis Suppurativa 80mg/0.8ml and 40mg/0.4ml Starter pack <input type="checkbox"/> Adolescent Hidradenitis Suppurativa 40mg/0.4ml Starter Package <input type="checkbox"/> Hidradenitis Suppurativa 80mg/0.8ml Starter pack <input type="checkbox"/> Hidradenitis Suppurativa 40mg/0.4ml Starter pack <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> Adolescents 12 years and older 66 lbs to <132 lbs: Inject 80mg SC on day 1, then 40mg SC on day 8 and every other week thereafter <input type="checkbox"/> Adolescents 12 years and older >132 lbs: Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="checkbox"/> Adolescents 12 years and older >132 lbs: Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Adolescents 12 years and older 66 lbs to <132 lbs: Inject 40mg every other week <input type="checkbox"/> Adolescents 12 years and older >132 lbs: Inject 40mg on day 29 then Inject 40mg every week	3 4 3 6	0 0 0 0
<input type="checkbox"/> HUMIRA®	Juvenile Idiopathic Arthritis + Pediatric Uveitis <input type="checkbox"/> 10mg/0.1ml Prefilled Syringe <input type="checkbox"/> 20mg/0.2ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe	<input type="checkbox"/> 22 lbs to <33 lbs: Inject 10mg SC every other week <input type="checkbox"/> 33 lbs to <66 lbs: Inject 20mg SC every other week <input type="checkbox"/> ≥66 lbs: Inject 40mg SC every other week	2	
<input type="checkbox"/>				

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.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.

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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
<input type="checkbox"/> HUMIRA®	Pediatric Crohn's Disease <input type="checkbox"/> Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml <input type="checkbox"/> Pediatric Crohn's Starter Pack: 80mg/0.8ml <input type="checkbox"/> 20mg/0.2ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> 37 lbs to <88 lbs: Inject one 80mg pen SC on day 1, then one 40mg pen SC on day 15 <input type="checkbox"/> >88 lbs: Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="checkbox"/> >88 lbs: Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15	2	0
		<input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 37 lbs to <88 lbs: Inject 20mg SC every other week <input type="checkbox"/> >88 lbs: Inject 40mg SC every other week	3	0
		<i>All strengths and dosages listed are Humira® Citrate Free</i>	2	
<input type="checkbox"/> STELARA®	Pediatric Plaque Psoriasis <input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 45mg/0.5ml Single-Dose Vial <input type="checkbox"/> 90 mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> <60 kg: Inject 0.75mg/kg SC at Week 0 <input type="checkbox"/> 60 – 100 kg: Inject 45mg SC at Week 0 <input type="checkbox"/> >100 kg: Inject 90mg SC at Week 0	1	0
		<input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> <60 kg: Inject 0.75mg/kg SC at Week 4, then every 12 weeks thereafter <input type="checkbox"/> 60 – 100 kg: Inject 45mg SC at Week 4, then every 12 weeks thereafter <input type="checkbox"/> >100 kg: Inject 90mg SC at Week 4, then every 12 weeks thereafter	1	0
				0
<input type="checkbox"/> TALTZ®	Pediatric Plaque Psoriasis <input type="checkbox"/> 80mg/ml Single-Dose Prefilled Autoinjector <input type="checkbox"/> 80 mg/ml Single-Dose Prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> >50 kg: Inject 160mg SC (two 80mg injections) at week 0 <input type="checkbox"/> 25 to 50 kg: Inject 80 mg SC at week 0 <input type="checkbox"/> <25 kg: Inject 40mg SC at week 0	2	0
		<input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> >50 kg: Inject 80mg SC at week 4 and every 4 weeks thereafter <input type="checkbox"/> 25 to 50 kg: Inject 40 mg SC at week 4 and every 4 weeks thereafter <input type="checkbox"/> <25 kg: Inject 20 mg at week 4 and every 4 weeks thereafter	1	0
		<i>20 mg and 40 mg doses for patients weighing ≤50 kg (110 lb) must be prepared and administered by a qualified healthcare professional.</i>		
<input type="checkbox"/>				

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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