PEDIATRIC IMMUNOLOGY ENROLLMENT FORM

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

KLOUDSCRIPT Community Led Specialty Pharmacy Care

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 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
❑ 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:** ❑ ≥**60 kg:** Inject 600mg SC (two 300mg injections) ❑ **30 to <60 kg:** Inject 400mg SC (two 200mg injections) ❑ **15 to <30 kg:** Inject 600mg SC (two 300mg injections)	2	0
		❑ **Maintenance Dose:** ❑ ≥**60 kg:** Inject 300mg SC every other week ❑ **30 to <60 kg:** Inject 200mg SC every other week ❑ **15 to <30 kg:** Inject 300mg SC every 4 weeks		
❑ 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 ❑ 40mg/0.4ml Prefilled Syringe	❑ **Induction Dose:** ❑ **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 ❑ **Adolescents 12 years and older >132 lbs:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ❑ **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	3 4 3 6	0 0 0 0
		❑ **Maintenance Dose:** ❑ **Adolescents 12 years and older 66 lbs to <132 lbs:** Inject 40mg every other week ❑ **Adolescents 12 years and older >132 lbs:** Inject 40mg on day 29 then Inject 40mg every week	2	
❑ HUMIRA®	**Juvenile Idiopathic Arthritis + Pediatric Uveitis** ❑ 10mg/0.1ml Prefilled Syringe ❑ 20mg/0.2ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe	❑ **22 lbs to <33 lbs:** Inject 10mg SC every other week ❑ **33 lbs to <66 lbs:** Inject 20mg SC every other week ❑ **≥66 lbs:** Inject 40mg SC every other week	2	
❑ _____	_____	_____		

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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_____% BSA affected
❑ Scalp ❑ Face ❑ Chest ❑ Arms ❑ Hands ❑ Nails
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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

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

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.