PEDIATRIC HUMIRA® ENROLLMENT FORM

PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

Phone: **844-223-7510**
Fax: **844-673-6161**

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: ______________
Office Contact: ______________ Phone: ______________
Email: ______________________

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ______________ ICD-10: ______________

Other: ______________________

TB Test: ❑ Positive ❑ Negative Date: ______________

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	______________

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

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

6 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

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®	**Hidradenitis Suppurativa** ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ 80mg/0.8ml Pen ❑ 80mg/0.8ml 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 ❑ **Adolescents 12 years and older >132 lbs:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15, then 40mg on day 29 ❑ **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		
		❑ **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 every week		
❑ 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 ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ **22 lbs to <33 lbs:** Inject 10mg SC every other week ❑ **33 lbs to <66 lbs:** Inject 20mg SC every other week ❑ **>= 33 lbs:** Inject 40mg SC every other week	2	
❑ HUMIRA®	**Pediatric Crohn's Disease** ❑ 20mg/0.2ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml (pack of 2) ❑ Pediatric Crohn's Starter Pack: 80mg/0.8ml (pack of 3)	❑ **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 week		
	All strengths and dosages listed are Humira® Citrate Free			
❑ ________	______________	______________		

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: ________
Substitution Permitted

Signature: ______________ Date: ________
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.