RED CROSS PHARMACY
Our Family Caring For Yours

# PSORIASIS SPECIALTY CARE PROGRAM

Phone: **888-216-1949** • Fax: **888-977-1391**

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
❑ Hands ❑ Scalp ❑ Feet ❑ Groin ❑ Nails

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:**
❑ Automatically Draft Appeal for Review
❑ Send Preferred Formulary Alternatives

| Prior Failed Treatments: | Indicate Drug Name and Length of Treatment: |
|---|---|
| ❑ Topicals | |
| ❑ Methotrexate | |
| ❑ Oral Meds | |
| ❑ Biologics | |
| ❑ UVA ❑ UVB | |
| ❑ Others | |

## 4 INJECTION TRAINING:
❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ 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™ | ❑ 150mg/ml Sensoready® Pen<br>❑ 150mg/ml Prefilled Syringe | ❑ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4 | 10 | 0 |
| | | ❑ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4 | 5 | 0 |
| | | ❑ **Maintenance Dose:** Inject 300mg SC every four weeks | 2 | |
| | | ❑ **Maintenance Dose:** Inject 150mg SC every four weeks | 1 | |
| ❑ ENBREL® | ❑ 50mg/ml Sureclick Autoinjector | ❑ **Induction Dose:** Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing | 8 | 2 |
| | ❑ 50mg/ml Prefilled Syringe<br>❑ 25mg Lyophilized Powder Multiple Dose Vial<br>❑ Other: _____ | ❑ **Maintenance:** Inject 50mg SC once a week | 4 | |
| | | **Pediatric Patients:** To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder | | |
| | | ❑ > 138lbs or more: Inject 50mg weekly | 4 | |
| | | ❑ < 138lbs: Inject 0.8mg/kg weekly | | |
| | | ❑ Other: _____ | | |
| ❑ HUMIRA® | ❑ Psoriasis Starter Package | ❑ **Induction Dose:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week | 4 | 0 |
| | ❑ 40mg/0.8ml Pen<br>❑ 40mg/0.8ml Prefilled Syringe | ❑ **Maintenance:** Inject 40mg SC every other week<br>❑ Other: _____ | 2 | |
| | ❑ Hidradenitis Suppurativa Starter Package | ❑ **Induction Dose:** Inject 160mg SC on day 1 (or 80mg on day 1 and 80mg on day 2), then 80mg SC on day 15, then switch to maintenance dose on day 29 | 6 | 0 |
| | ❑ 40mg/0.8ml Pen<br>❑ 40mg/0.8ml Prefilled Syringe | ❑ **Maintenance:** Inject 40mg SC every week | 4 | |
| | ❑ *Patient has signed HUMIRA Complete form* | | | |
| ❑ OTEZLA® | ❑ Starter Pack (Titration) | ❑ **Starter Pack:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack | 1 | 0 |
| | ❑ 30mg Tablets | ❑ **Maintenance:** Take one 30mg tablet by mouth twice daily | 60 | |
| | ❑ Bridge Dose Pack | ❑ Take one 30mg tablet by mouth twice daily | 28 | |
| ❑ RASUVO® | ❑ _____ | ❑ _____ | | |
| ❑ SIMPONI® (for PsA) | ❑ 50mg/0.5ml Smartject Injector<br>❑ 50mg/0.5ml Prefilled Syringe | ❑ Inject 50mg SC once a month | 1 | |
| ❑ STELARA® | ❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs) | ❑ **Induction Dose:** Inject the contents of 1 prefilled syringe SC on day 1 | 1 | 0 |
| | ❑ 90mg/1ml Prefilled Syringe (for > 220 lbs) | ❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter | 1 | |
| | ❑ Yes or ❑ No: ***STELARA SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection* | | | |
| ❑ _____ | _____ | _____ | | |

## 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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