

## **Dermatology Enrollment Form**

Fax Referral To: 1-855-297-1270PhorAddress: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

Phone: 1-888-280-1190 0982 NCPDP: 4026325

				eferral	
	<b>DRMATION</b> (Comple	ete or include demogra	phic sheet)		
Patient Name:				Gender: 🗌 Ma	ale 🗌 Female
Address:		(	City, State, ZIP Code:		
Preferred Contact M	1ethods: 🗌 Phone (to pri	mary # provided below) 🗌 <sup>.</sup>	Text (to cell # provided	below) 🗌 Email (to er	nail provided below)
					omated calls, emails and/or text
messages from CVS :	Specialty® about your prese	ription(s), account, and health	care. Standard data rate	s apply. Message freque	ncy varies. If unable to contact via
ext or email, Special	ty Pharmacy will attempt to	contact by phone.			
Email:					
		;t, First):	Relationship to pa	tient:	
	INFORMATION				
Prescriber's Name:			State License #	:	
NPI #:	DEA #:	Group or Hospit	tal:		
Address:			City, State, ZIP Code:		
Phone:	Fax	Contact Person:		Contact's Phone:	
		se fax copy of prescription			
		the Patient enrolled or eligibl			
					hip to Patient:
Medical Insurance		Telenhone <sup>.</sup>	Policy ID:	Gro	un #·
Prescription Insurar	100:		Prescription Plan Tele	phone:	RX PCN #:
Policy ID:		Group #:	- ' RX BIN #:		RX PCN #:
Check box if pati	ient is enrolled in manufa	cturer copay assistance	If yes, please prov	ride ID#	
DIAGNOSIS	ND CLINICAL INFO	RMATION			
		Ship to: 🗌 Patient 🗌 Of	fice 🗌 Other:		
Diagnosis (ICD					
L28.1 Prurigo No		0.0 Psoriasis Vulgaris		zed Pustular Psoriasis	
L28.1 Prungo No		0.50 Arthropathic Psoriasis,	L40.1 Generall	zeu Pustular Psoriasis	
	provincialisL4	0.59 Other Psoriatic Arthrop	onspecified	oriocic	
					asta unspecified
$\square$ L40.9 PS011asis, 0	Unspecified is Suppurativa	Other Code:			
			_ Description		
Patient Clinical					
Allergies:			TD Toot Dooult		Noto:
Weight:	ID/Kg Heigr	it:In/cm for discontinuation:	TE Test Result:		Date:
Frior therapy, treath	$\Box$ Now to the reput	ntinuation of therapy; date of	lost tro stmont /	/ Neede by dete:	
		innuation of therapy, date of		/ Neeus by date	
Nursing and Ad					
		th Infusion nurse visit as nec			
		Ambulatory Infusion Suite (A		Office** Other Infu	sion Clinic
		three doses to be given in c	-	. //	
*Home Infusion/Cor	ram AIS: Diluents, Flushe	s, Supplies, Nursing Services	s for drug administratio		
*Home Infusion/Cor **Prescriber's Office	ram AIS: Diluents, Flushe e/Other Infusion Clinic: D	-	s for drug administratio		
*Home Infusion/Cor **Prescriber's Office <b>PRESCRIPTIC</b>	ram AIS: Diluents, Flushe e/Other Infusion Clinic: D DN INFORMATION	s, Supplies, Nursing Services	s for drug administratio		
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Home Infusion/Cor Prescriber's Office PRESCRIPTIC MEDICATION  Adalimumab- aacf (Unbranded Idacio)  Adalimumab- aaty (unbranded version of Yuflyma)  Patient is interested in patie	ram AIS: Diluents, Flushe e/Other Infusion Clinic: D DN INFORMATION STRENGTH 40 mg/0.8 mL PEN 40 mg/0.8 mL PFS 1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN Strength: 	s, Supplies, Nursing Services rug only for facility administr Inject 40 mg SC eve Inject 40 mg SC eve Inject 80 mg SC eve Inject 80 mg Day 1, week after initial dose Inject 40mg SC eve Inject 40mg SC eve Inject 40mg SC eve Inject 80 mg Day 1, week after initial dose Inject 80 mg Day 1, week after initial dose	s for drug administratio ration DOSE & DIRECTIC ery week ery other week ery other week followed by 40 mg eve ery week ery other week ery other week followed by 40 mg eve	PNS ry other week starting ry other week starting Ancillary supplies and kits prov	Dene 28 days 28 days Refills: 28 days 28 days 84 days Refills: Quantity:
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Home Infusion/Cor  Prescriber's Office  PRESCRIPTIC Adalimumab- aacf (Unbranded Idacio)  Adalimumab- aaty (unbranded version of Yuflyma)  Patient is interested in patie PRESCRIBER "Dispense As Written"	ram AIS: Diluents, Flushe e/Other Infusion Clinic: D DN INFORMATION STRENGTH 40 mg/0.8 mL PEN 40 mg/0.8 mL PFS 1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN Strength: nt support programs SIGNATURE REQUI	s, Supplies, Nursing Services rug only for facility administr Inject 40 mg SC eve Inject 40 mg SC eve Inject 80 mg SC eve Inject 80 mg Day 1, week after initial dose Inject 40mg SC eve Inject 40mg SC eve Inject 40mg SC eve Inject 80 mg Day 1, week after initial dose Inject 80 mg Day 1, week after initial dose	s for drug administratio ration DOSE & DIRECTIC ery week ery other week followed by 40 mg eve ery week ery other week followed by 40 mg eve distribution of the second followed by 40 mg eve May Substitute	PNS ry other week starting ry other week starting Ancillary supplies and kits prov ED) e / Product Selection Permi	28 days         84 days         Refills:         28 days         28 days         84 days         928 days         929 days <td< td=""></td<>
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		ermatology Enrol		
			d Patient Clinical Information	
			Patient Phone:	
Patient Address: Prescriber Name:			none:	
Prescriber Name			ione	
Allergies:				
Weight:	lb/kg Height:	In/cm TB T	est Result: Date: _	
	<b>DN INFORMATION</b>			
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	<b>QUANTITY/REFILLS</b>
		🗌 Inject 40 mg SC every week		
		Inject 40 mg SC every other		
Adalimumab-		Inject 80 mg SC every other		
adaz	40 mg/0.4 mL PEN		llowed by 40 mg every other week	Quantity:
(unbranded version of	40 mg/0.4 mL PFS (with needle guard)	starting one week after initial do	ingle-dose or split over two consecutive	28 days
Hyrimoz)	(with heedle guard)		) mg every week starting on Day 29	Refills:
119111102)			ingle-dose or split over two consecutive	
			O mg every other week starting on Day 29	
		Inject 40 mg SC every week		
		Inject 40 mg SC every other	week	
🗌 Adalimumab-		Inject 80 mg SC every other		
fkjp	40 mg/0.8 mL PFS		llowed by 40 mg every other week	Quantity:
(unbranded	40 mg/0.8 mL PEN	starting one week after initial do		28 days
version of Hulio)			ingle-dose or split over two consecutive Omg every week starting on Day 29	B4 days Refills:
			ingle-dose or split over two consecutive	Renus:
			) mg every other week starting on Day 29	
		Inject 40 mg SC every week		
		Inject 40 mg SC every other		
	40 mg/0.8 mL PFS	🔲 Inject 80 mg SC every other	week	Quantity:
🗌 Amjevita	40 mg/0.8 mL PEN		by 40 mg every other week starting one	28 days
(adalimumab-atto)		week after initial dose		84 days
			iven in one day or split over two	Refills:
		every other week dosing two w	ay 15. Begin 40 mg weekly or 80 mg	
			5 mg/kg (Dose =mg) at weeks	Quantity:
<b>—</b>		0, 2, 6 and every 8 weeks there		# of 100 mg vial(s)
🗌 Avsola	100 mg vial	Maintenance Dose: Infuse IV		Refills:
		(Dose =mg) every 8 weeks	0.0	
		PsO Loading Dose:		Quantity: 28 DS
		🗌 Inject 320 mg (2 x 160 mg/n	nL) SC at weeks 0, 4, 8, and 12	Refills: 3
		PsO Maintenance Dose:		Quantity: 56 DS
			nL) SC on week 16 and every 8 weeks	Refills:
	1 x 320 mg/2 mL PEN	thereafter		
Dimension	2 x 160 mg/mL PEN	PsO Maintenance Dose for pts	≥ 120 kg (264 lbs): 1L) SC on week 16 and every 4 weeks	Quantity: 28 DS
Bimzelx	1 x 320 mg/2 mL PFS	thereafter	IL) SC on week to and every 4 weeks	Refills:
	2 x 160 mg/mL PFS 2	HS Loading Dose:		Quantity: 28 DS
			nL) SC at week 0, 2, 4, 6, 8, 10, 12, and 14	Refills: 3
		HS Maintenance Dose:		Quantity: 28 DS
			nL) SC on week 16 and every 4 weeks	Refills:
		thereafter	-	
	Strength:	Dose:		Quantity:
Other				Refills:
Patient is interested in p		STAMP SIGNATURE NOT ALLOWED		vided as needed for administration
6 PRESCRIBER	SIGNATURE REQUI	RED (STAMP SIGNATU	RE NOT ALLOWED)	
		ot Substitute / No Substitution / DAW	May Substitute / Product Selection Permitted /	
/ May Not Substitute			Substitution Permissible	
Prescriber's Signa	ature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR: Interc	change is mandated unless Prescriber	writes the words "No Substitution"	ATTN: New York and Iowa providers, please	e submit electronic prescription

		natology Enrol ient, Prescriber an	d Patient Clinical Informat	ion
Patient Name:			Patient Phone:	
rescriber Name:		Prescriber Ph	ione:	
Patient Clinical Inform				
Mergies	lb/ka Height:		est Result: Dat	te:
MEDICATION	STRENGTH		OSE & DIRECTIONS	QUANTITY/REFILLS
MEDICATION	STRENGTH	Psoriasis Loading Dose		QUANTIT I/ REFILLS
🗌 Cimzia	Cimzia Starter Kit (6 prefilled syringes)	<ul> <li>400 mg (given as 2 every other week</li> <li>Patients (with body 2 subcutaneous injecti 2 and 4, followed by 20 Psoriatic Arthritis Load</li> <li>400 mg (given as 2</li> </ul>	subcutaneous injections of 200 mg ea weight ≤ 90 kg): 400 mg (given as ons of 200 mg each) initially and at we 00 mg every other week	eeks Quantity: 1 Kit Refills: 0 ach)
🗌 Cimzia	200 mg/1 mL prefilled syringe	Psoriasis Maintenance 400 mg (given as 2 every other week 200 mg every other Psoriatic Arthritis Main 200 mg every other	subcutaneous injections of 200 mg ea week tenance Dose:	Quantity: Refills:
Cosentyx	<ul> <li>☐ 75 mg/0.5 mL PFS</li> <li>☐ 150 mg/mL PEN</li> <li>☐ 150 mg/mL PFS</li> <li>☐ 150 mg/mL PEN</li> <li>☐ 150 mg/mL PFS</li> <li>☐ 300 mg/2 mL PEN</li> </ul>	☐ Inject 75 mg SC eve ☐ Inject 150 mg SC or ☐ Inject 150 mg SC ev	a Weeks 0, 1, 2, 3 n Weeks 0, 1, 2, 3 Week 4, then every 4 weeks thereafte ery 4 weeks a Week 4, then every 4 weeks thereaft ery 4 weeks n Week 4, then every 4 weeks thereaft very 4 weeks	Quantity: <u>28 days</u> er Refills:
Dupixent	PFS 300 mg/2 mL prefilled syringe Pen 300 mg/2 mL prefilled pen	Loading Dose: Inject 600 mg SC (2 300 mg SC every 2 we Maintenance Dose: Inject 300 mg SC e		Quantity: 28-day supply by 84-day supply Other: Day supply Refills: 1 year Other: Refills
🗌 Enbrel	<ul> <li>☐ 50 mg/mL Mini</li> <li>☐ 50 mg/mL PEN</li> <li>☐ 50 mg/mL PFS</li> <li>☐ 25 mg/0.5 mL PFS</li> <li>☐ 25 mg/0.5 mL Vial</li> </ul>	Loading Dose: Inject 50 mg SC twi 3 months, then mainte <u>Maintenance Dose</u> : Inject 50 mg SC on Inject mg S	ce weekly	Loading Dose: Quantity: <u>84 days</u> Refills: <u>0</u> <u>Maintenance Dose</u> : Quantity: <u>28 days</u> Refills:
Other	Strength:	Dose:		Quantity: Refills:
Patient is interested in patie	IGNATURE REQUIRED	SIGNATURE NOT ALLOWED		s provided as needed for administration
		•	-	
/ May Not Substitute	and Medically Necessary / Do Not Subs		May Substitute / Product Selection Permitte Substitution Permissible <b>Prescriber's Signature:</b>	

# **Dermatology Enrollment Form**

	Please Comp	lete Patient, Prescriber an	d Patient Clinical Information	
Patient Name:			Patient Phone:	
	6:			
Prescriber Nam		Prescriber Ph	one:	
Patient Clinica				
Allergies:				
Weight:			est Result: Date: _	
	PTION INFORMATIO			
MEDICATIO	N STRENGTH		DIRECTIONS	QUANTITY/REFILLS
		Inject 40 mg SC every week		
		☐ Inject 40 mg SC every other we		
	🗌 40 mg/0.4 mL PEN	☐ Inject 80 mg SC every other we	ек ed by 40 mg every other week starting	Quantity:
🗌 Hadlima	🗌 40 mg/0.8 mL PEN	one week after initial dose	ed by 40 mg every other week starting	28 days
	40 mg/0.4 mL PFS		e-dose or split over two consecutive	B4 days
	40 mg/0.8 mL PFS	days), 80 mg on Day 15, then 40 mg		Refills:
			e-dose or split over two consecutive	
		days), 80 mg on Day 15, then 80 mg	gevery other week starting on Day 29	
		Inject 40 mg SC every week		
		Inject 40 mg SC every other we		
		Inject 80 mg SC every other we		Quantity:
<b>—</b>	40 mg/0.8 mL PFS		ed by 40 mg every other week starting	28 days
🗌 Hulio	40 mg/0.8 mL PEN	one week after initial dose	a daaa ay anlit ay ay tug aanaa ay tiya	Bafiller
		days), 80 mg on Day 15, then 40 mg	e-dose or split over two consecutive	Refills:
			e-dose or split over two consecutive	
			g every other week starting on Day 29	
		☐ Inject 40 mg SC every week	, ,	
		Inject 40 mg SC every other we	ek	
		Inject 80 mg SC every other we		
	☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen	🗌 Inject 80 mg SC on day 1, then 4	0 mg every other week on day 8 and	28 days
🗌 Humira	80 mg/0.8 mL PFS	subsequent doses		🗌 84 days
	80 mg/0.8 mL Pen		e-dose or split over two consecutive	Refills:
		days), 80 mg on Day 15, then 40 mg		
			e-dose or split over two consecutive	
		Inject 40 mg SC every week	g every other week starting on Day 29	
		☐ Inject 40 mg SC every week	ak	
		☐ Inject 80 mg SC every other we		28 days
	40 mg/0.4 mL PEN		ed by 40 mg every other week starting	84 days
🗌 Hyrimoz	40 mg/0.4 mL PFS	one week after initial dose	, , , , , , , , , , , , , , , , , , , ,	Refills:
	(with needle guard)	🗌 Inject 160 mg SC on Day 1 (singl	e-dose or split over two consecutive	
		days), 80 mg on Day 15, then 40 mg		
			e-dose or split over two consecutive	
			g every other week starting on Day 29	
	100 mg/mL prefilled	<u>Psoriasis Induction Dose</u> : Inject	, , ,	Quantity
🗌 Ilumya	syringe	(100 mg) SC at weeks 0 and 4, then Psoriasis Maintenance Dose: Inj		Quantity: Refills:
		(100 mg) SC every 12 weeks.	ect one pre-med syninge	
	Ctron othe			Overstite #
Other	Strength:	Dose:		Quantity: Refills:
Patient is interested	d in patient support programs	STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits prov	rided as needed for administration
		QUIRED (STAMP SIGNATU		
		/ Do Not Substitute / No Substitution / DAW	May Substitute / Product Selection Permitted /	
/ May Not Substit			Substitution Permissible	
Prescriber's	Signature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR	: Interchange is mandated unless Pre	scriber writes the words "No Substitution"	ATTN: New York and Iowa providers, please	submit electronic prescription

		Dermatology Enrollment Form	
	Please Comp	olete Patient, Prescriber and Patient Clinical Information	
		Patient DOB:Patient Phone:	
		Prescriber Phone:	
Patient Clinical			
Allergies:		ht: In/cm TB Test Result: Date:	
		NI Date Date Date	
MEDICATION	STRENGTH	DOSE & DIRECTIONS	OUANTITY /DEFUL
Inflectra	STRENGTH	Induction Dose: Infuse IV at 5 mg/kg	<b>QUANTITY/REFILL</b> Quantity:
	100 mg vial	(Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter	# of 100 mg vial(s)
🗌 Infliximab		<u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks	Refills:
Leqselvi	8 mg tablet	Take 8 mg orally twice daily with or without food	30 days 90 days
			Refills:
			28 days
Litfulo	50 mg capsule	Take 50 mg orally once daily with or without food	84 days
			Refills: Quantity:
🗌 Olumiant	2 mg tablet	2 mg PO once daily	Refills:
	4 mg tablet	4 mg PO once daily	
🗌 Orencia	125 mg/mL prefilled	Inject 125 mg SC once weekly	Quantity:
	syringe		Refills:
☐ Otezla	Titration Starter Pack for 30 mg BID dosage	<ul> <li>Adult Patients and Pediatric Patients 6 years of age and older weighing 50 kg or more:</li> <li>Day 1: 10 mg PO in the morning.</li> <li>Day 2: 10 mg PO in the morning and 10 mg PO in the evening.</li> <li>Day 3: 10 mg PO in the morning and 20 mg PO in the evening.</li> <li>Day 4: 20 mg PO in the morning and 20 mg PO in the evening.</li> <li>Day 5: 20 mg PO in the morning and 30 mg PO in the evening.</li> <li>Day 6 and thereafter: 30 mg PO twice daily.</li> </ul>	
	Titration Starter Pack for 20 mg BID dosage	<ul> <li>Pediatric Patients 6 years of age and older weighing 20 kg to less than 50 kg: Day 1: 10 mg PO in the morning.</li> <li>Day 2: 10 mg PO in the morning and 10 mg PO in the evening.</li> <li>Day 3: 10 mg PO in the morning and 20 mg PO in the evening.</li> <li>Day 4: 20 mg PO in the morning and 20 mg PO in the evening.</li> <li>Day 5: 20 mg PO in the morning and 20 mg PO in the evening.</li> <li>Day 5: 20 mg PO in the morning and 20 mg PO in the evening.</li> <li>Day 6 and thereafter: 20 mg PO twice daily.</li> </ul>	Quantity: 1 pack Refills: 0
🗌 Otezla	<ul> <li>20 mg tablet</li> <li>30 mg tablet</li> <li>Sample already provided/no titration needed</li> </ul>	<ul> <li>20 mg PO twice daily</li> <li>30 mg PO twice daily</li> </ul>	☐ 30 days ☐ 90 days Refills:
Other	Strength:	Dose:	Quantity: Refills:
	l in patient support programs	STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as	needed for administration
6 PRESCRIB	ER SIGNATURE RE	QUIRED (STAMP SIGNATURE NOT ALLOWED)	

#### "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW May Substitute / Product Selection Permitted / / May Not Substitute Substitution Permissible Prescriber's Signature: Prescriber's Signature: Date: Date:

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty

Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Patient Name: Patient Address:		e Patient, Prescriber and Patient Clinical Information	
Prescriber Name:         Patient Clinical Information:         Allergies:         Weight:       lb/l         PRESCRIPTION INFORM         MEDICATION       STREM         45 mg/0.5 n         90 mg/mL p         syringe         90 mg/mL p         syringe         100 mg vial         Renflexis         Rinvoq       15 mg         Selarsdi       asyringe         90 mg/mL p         syringe         90 mg vial         90 mg vial         90 mg/mL p         syringe         100 mg vial         90 mg/mL p         90 mg/mL p         90 mg vial         90 mg/mL p		Patient DOB:Patient Phone:	
Patient Clinical Information:         Allergies:         Weight:		Prescriber Phone:	
PRESCRIPTION INFORM         MEDICATION       STREM            □ Pzychiva           □ 45 mg/0.5 n         □ 90 mg/mL p         syringe             □ Pzychiva           □ 30 mg/mL p         syringe             □ Remicade           100 mg vial             □ Rinvoq           □ 15 mg             □ Selarsdi           □ 90 mg/mL p			
PRESCRIPTION INFORM         MEDICATION       STREM            □ Pzychiva           □ 45 mg/0.5 n         □ 90 mg/mL p         syringe             □ Pzychiva           □ 30 mg/mL p         syringe             □ Remicade           100 mg vial             □ Rinvoq           □ 15 mg             □ Selarsdi           □ 90 mg/mL p			
MEDICATION       STREM            □ Pzychiva           □ 45 mg/0.5 n         □ 45 mg/0.5 n         syringe         □ 90 mg/mL p         syringe         □ 90 mg/mL p         syringe         □ 90 mg/mL         p         syringe         □ 100 mg vial         □ Renflexis         □ Rinvoq         □ 15 mg         □ 45 mg/0.5 n         □ 90 mg/mL         □ 90 mg/mL         □         □ Selarsdi         □ 90 mg/mL         □         □ 90 mg/mL         □         □ 90 mg/mL         □         □ 90 mg/mL         □         □         □ 90 mg/mL         □         □         □		In/cm TB Test Result: Date:	
<ul> <li>Pzychiva</li> <li>□ 45 mg/0.5 n</li> <li>□ 45 mg/0.5 n</li> <li>□ 90 mg/mL p</li> <li>syringe</li> <li>□ 90 mg/mL p</li> <li>syringe</li> <li>100 mg vial</li> <li>□ Renflexis</li> <li>□ Rinvoq</li> <li>15 mg</li> <li>□ Selarsdi</li> <li>□ Selarsdi</li> </ul>			
<ul> <li>□ Pzychiva</li> <li>□ 45 mg/0.5 n syringe</li> <li>□ 90 mg/mL p syringe</li> <li>□ Remicade</li> <li>□ Renflexis</li> <li>□ Rinvoq</li> <li>15 mg</li> <li>□ Selarsdi</li> <li>□ Selarsdi</li> <li>□ 90 mg/mL p</li> </ul>	IGTH	DOSE & DIRECTIONS PsO Peds patients (6 to 17yo):	QUANTITY/REFILL
□ Renflexis       100 mg vial         □ Rinvoq       15 mg         □ Rinvoq       15 mg         □ Selarsdi       □ 45 mg/0.5 mg/0	nL prefilled	□       < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter.	Quantity: Refills:
□ Rinvoq 15 mg □ 45 mg/0.5 n □ 45 mg/0.5 n □ 45 mg/0.5 n syringe □ 90 mg/mL p		Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter	Quantity: # of 100 mg vial(s)
☐ 45 mg/0.5 n ☐ 45 mg/0.5 n ☐ Selarsdi syringe ☐ 90 mg/mL p		Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks	Refills:
☐ 45 mg/0.5 n Selarsdi = 90 mg/mL p		Take one 15 mg tablet PO daily	Quantity: Refills:
	nL prefilled	PsO Peds patients (6 to 17yo):         □ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter.	Quantity: Refills:
Other Strength:		Dose:	Quantity:
Patient is interested in patient support p		STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as n	Refills:

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Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
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	I	Dermatology Enrollment Form	
		e Patient, Prescriber and Patient Clinical Information	
Patient Name: _		Patient DOB:Patient Phone:	
Patient Address	8:		
Prescriber Nam	ie:	Prescriber Phone:	
	al Information:		
Allergies:	lb/kg Height: _		
weight:	lb/kg Height: _	In/cm TB Test Result: Date:	
5 PRESCRIP	TION INFORMATION		
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILL
🗌 Siliq	Carton of two 210 mg/1.5 mL single-dose prefilled syringes	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210 mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: <u>SILIQ REMS Website</u> (https://siliqrems.com/SiliqUI/home.u)	Quantity: Refills:
Simlandi (adalimumab- ryvk)	☐ 40 mg/0.4mL PEN	<ul> <li>Inject 40 mg SC every week</li> <li>Inject 40 mg SC every other week</li> <li>Inject 80 mg SC every other week</li> <li>Inject 80 mg Day 1, followed by 40mg every other week starting one week after initial dose</li> <li>Inject 160 mg SC on Day 1, (given in one day or split over two consecutive days), 80mg on Day 15. Begin 40mg weekly or 80mg every other week dosing two weeks later starting day 29.</li> </ul>	Quantity: 28 days 84 days Refills:
🗌 Simponi	50 mg/0.5 mL SmartJect Autoinjector 50 mg/0.5 mL prefilled syringe	Psoriatic Arthritis Dose: Inject 50 mg SC once a month.	Quantity: Refills:
Simponi ARIA	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks	Quantity: # of 50 mg vial Refills:
Skyrizi	☐ 150 mg/mL single-dose Pen ☐ 150 mg/mL single-dose prefilled syringe	<u>Psoriasis Induction Dose</u> : Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. <u>Psoriasis Maintenance Dose</u> : Inject 150 mg SC every 12 weeks.	Quantity: Refills:
Sotyktu	6 mg tablet	Take one 6 mg tablet PO once daily	Quantity: Refills:
☐ Stelara	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo):         □ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter.	Quantity: Refills:

"Dispense As Written" / Brand Medically Necessary / Do I May Not Substitute <b>Prescriber's Signature:</b>	Not Substitute / No Substitution / DAW /	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:
<b>6</b> PRESCRIBER SIGNATURE REQUIR	ED (STAMP SIGNATURE NO	T ALLOWED)	
Patient is interested in patient support programs	STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits pro	vided as needed for administration

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		<b>Dermatology Enrol</b>	lment Form		
		ete Patient , Prescriber a	nd Patient Clinical Info		
		Patient DOB:			
Patient Address: Prescriber Name		Prescriber P			
Patient Clinical	Information:				
Allergies:		::In/cm TB `			
Weight:	lb/kg Height	:In/cm TB `	Test Result:	Date:	······
	TION INFORMATION				
MEDICATION	STRENGTH	DOSE PsO Peds patients (6 to 17yo):	& DIRECTIONS		QUANTITY/REFILLS
☐ Steqeyma	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe		C at weeks 0 and 4, then every eeks 0 and 4, then every 12 wee at weeks 0 and 4, then every eks 0 and 4, then every 12 week severe PsO: Inject 90 mg SC at s thereafter. (220 lbs): Inject 45 mg SC initial ery 12 weeks. (220 lbs): Inject 90 mg SC initial ery 12 weeks. (220 lbs): Inject 90 mg SC initial ery 12 weeks. (4, then every 12 weeks thereaft ent mod-severe PsO: Inject 90 m	ks s ly and 4 ly and 4 iter.	Quantity: Refills:
☐ Taltz	<ul> <li>■ 80 mg/mL PEN</li> <li>■ 80 mg/mL PFS</li> <li>■ 40 mg/0.5 mL PFS</li> <li>■ 20 mg/0.25 mL PFS</li> <li>■ 100 mg/mL PEN</li> <li>■ 100 mg/mL PFS</li> </ul>	Psoriasis Dosing:  Starting Dose: Inject two 80 mg induction dose 2 weeks later Induction Dose: Inject one 80 m Final Induction Dose: Inject one 80 m Maintenance Dose: Inject one 8 Pediatric Psoriasis Dosing (6 yea Patients weighing less than 25 kg: Inject 40 mg SC at Week 0, foll Patients weighing greater than 50 Inject 160 mg (two 80 mg inject every 4 weeks Psoriatic Arthritis Dosing: Starting Dose: Inject SC two 80 Starting Dose: Inject 100 mg SC	g SC injections on Day 1, then being injection SC every 2 weeks ( 80 mg injection SC week 12 30 mg injection SC every 4 wee <b>rs and older):</b> owed by 20 mg every 4 weeks owed by 40 mg every 4 weeks <u>kg:</u> tions) SC at Week 0, followed b mg injections on Day 1 he 80 mg injection every 4 wee	weeks 2-10) ks y 80 mg ks	Quantity: 28 days 84 days Refills:
🗌 Tremfya	100 mg/mL One- Press patient-controlled injector	dosing Maintenance Dose: Inject 100 r			Refills:
Other	Strength:	Dose:			Quantity: Refills:
	in patient support programs	STAMP SIGNATURE NOT ALLOWED		es and kits provid	ed as needed for administration
PRESCRIB	EK SIGNA I URE REQ	UIRED (STAMP SIGNATU	KE NUI ALLOWED)		
"Dispense As Writte DAW / May Not Sub		Do Not Substitute / No Substitution /	May Substitute / Product Selection Substitution Permissible	Permitted /	
Prescriber's S	ignature:	Date:	Prescriber's Signature:		Date:

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Pationt Namo:		e Patient, Prescriber and	Patient Phone:	
			Faueric Phone	
rescriber Name: _			none:	
atient Clinical Inf			ione	
llergies:				
/eight:	lb/ka Height:	In/cm TB T	est Result:	 Date:
	ON INFORMATION			
MEDICATION	STRENGTH	DOSE	DIRECTIONS	QUANTITY/REFILL
🗌 Ustekinumab	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): $\bigcirc$ < 60 kg: Inject 0.75 mg/kg SC	at weeks 0 and 4, then every 12 weeks 0 and 4, then every SC at weeks 0 and 4, then every weeks 0 and 4, then every 12 weeks C at weeks 0 and 4, then every reeks 0 and 4, then every 12 weeks d-severe PsO: Inject 90 mg SC at eks thereafter. g (220 lbs): Inject 45 mg SC initially g every 12 weeks. g (220 lbs): Inject 90 mg SC initially g every 12 weeks. nd 4, then every 12 weeks thereafter stent mod-severe PsO: Inject 90 mg	and and er.
🗌 Xeljanz	5 mg tablet 11 mg XR tablet	Take one 5 mg tablet PO twic Take one 11 mg PO once daily		Quantity: Refills:
Other	Strength:	Dose:		Quantity: Refills:
	patient support programs	STAMP SIGNATURE NOT ALLOWED		d kits provided as needed for administra
		Not Substitute / No Substitution / DAW	May Substitute / Product Selection Per	mitted /
/ May Not Substitute		Date:	Substitution Permissible Prescriber's Signature:	<b>-</b> .

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	I	Dermatology Enrollment Form	
		e Patient, Prescriber and Patient Clinical Information	1
		Patient DOB:Patient Phone:	
Prescriber Name:		Prescriber Phone:	
Patient Clinical In			
Allergies: Weight:	lb/ka Height:	In/cm TB Test Result: Date: _	
			·····
_			
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
Yesintek	<ul> <li>☐ 45 mg/0.5 mL vial</li> <li>☐ 45 mg/0.5 mL</li> <li>prefilled syringe</li> <li>☐ 90 mg/mL prefilled</li> <li>syringe</li> </ul>	PsO Peds patients (6 to 17yo):         □       < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter.	Quantity: Refills:
☐ Yuflyma	<ul> <li>40 mg/0.4 mL PEN</li> <li>40 mg/0.4 mL PFS</li> <li>40 mg/0.4 mL PFS</li> <li>40 mg/0.4 mL PFS</li> <li>(with safety guard)</li> <li>80 mg/0.8 mL PEN</li> </ul>	<ul> <li>Inject 40 mg SC every week</li> <li>Inject 40 mg SC every other week</li> <li>Inject 80 mg SC every other week</li> <li>Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose</li> <li>Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29</li> <li>Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29</li> </ul>	☐ 28 days ☐ 84 days Refills:
Other	Strength:	Dose:	Quantity: Refills:

# Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do No / May Not Substitute <b>Prescriber's Signature:</b>	t Substitute / No Substitution / DAW	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:		
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## Dermatology Enrollment Form Nursing Orders

Pl	ease Com	olete Patient, Prescriber and Patient Clinical Information	on	
		Patient DOB:Patient Phone:		
Patient Address:				
Prescriber Name:		Prescriber Phone:		
Patient Clinical Information	<u>on:</u>			
Allergies Weight:	lb/ka Heic	ght: In/cm TB Test Result: Date	······································	
		ON **ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DOM		
MEDICATION/SUPPLIES		DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS	
Catheter: PIV PORT CVC/PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV: NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL 3-5 mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: Refills:	
Hydration:	IV	Pre:   500 mL  1000 mL  Other: Concurrent:  500 mL  1000 mL  Other: Post:  500 mL  1000 mL  Other:	Hydration max infusion rate mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)	
Epinephrine **nursing requires**	□ IM □ SC	<ul> <li>1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs)</li> <li>1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs)</li> <li>1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg)</li> <li>Mild-Moderate Reactions. May repeat in 3-5 minutes as needed</li> <li>For severe allergic reaction also call 911</li> </ul>	Quantity: Refills:	
Diphenhydramine Oral	PO	Premedication:	Quantity: Refills:	
Diphenhydramine 50 mg/mL vial **nursing required**	Slow IV	<ul> <li>1 mg/kg (under 15 kg)</li> <li>12.5 mg-50 mg (15-30 kg)</li> <li>25 mg-50 mg (Over 30 kg)</li> <li>If mild/moderate reaction: may repeat in 3-5 minutes as needed (Adult max dose: 100 mg/day)</li> <li>If severe allergic reaction: call 911</li> </ul>	Quantity: Refills:	
Elush Orders:	Peripheral Access Central Venous Access	I 0 mL NS post flush 50 mL NS post flush (Recommended if no post-hydration) Other:	Send quantity sufficient for medication days supply	
Additional Medication:				
Patient is interested in patient supp <b>PRESCRIBER SIGN</b>		STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits QUIRED (STAMP SIGNATURE NOT ALLOWED)	provided as needed for administration	
"Dispense As Written" / Brand M DAW / May Not Substitute <b>Prescriber's Signature:</b>		y / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:	
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