Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

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PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______
Address ______
Address 2 ______
City, State, Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ Last Four of SS# ______ Gender ______
Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Group / Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ______

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

☐ L20 Atopic dermatitis
☐ L28.1 Prurigo nodularis
☐ L40.0 Psoriasis vulgaris
☐ L40.2 Acrodermatitis continua
☐ L40.4 Guttate psoriasis
☐ L40.1 Generalized pustular psoriasis
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis ______
☐ Other Diagnosis: ICD-10 Code ______ Description ______

Date of Diagnosis ______
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg / lbs Height ______ cm / in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______
Additional Comments ______
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty / Refills
☐ Abrilada™ (adalimumab-afzb)	☐ 20mg/0.4mL prefilled syringe ☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL pen	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Adbry® (tralokinumab-ldrm)	150mg/mL prefilled syringe	Induction Dose: Inject SC four 150mg injections on Day 1, followed by two 150mg injections every other week. Maintenance Dose: ☐ Inject SC two 150mg injections every other week. ☐ Inject SC two 150mg injections every four weeks. Consideration if body weight is below 100 kg, and completed 16 weeks of treatment.	Quantity: ______ Refills: ______
☐ Amjevita™ (adalimumab-atto)	☐ 40mg/0.8 mL Prefilled Syringe (citrate-free) ☐ 40mg/0.8 mL Prefilled SureClick® autoinjector (citrate-free) ☐ Other ______	☐ Psoriasis Induction Dose: Inject 80mg SC on day 1, followed by 40mg SC on day 8, then 40mg every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29 ☐ Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. ☐ Other ______	Quantity: ______ Refills: ______
☐ Avsola® (infliximab-axxq)	100mg Vial	☐ Induction Dose: Infuse 5mg/kg (Dose = ____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5mg/kg (Dose = ____mg) IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100mg vial Refills: ______
☐ Bimzelx® (bimekizumab-bkzx)	☐ 160mg/1mL autoinjector ☐ 160mg/1mL prefilled syringe	☐ Induction: inject 320mg (2 x 160mg injections) subcutaneously at weeks 0, 4, 8, 12, and 16 ☐ Maintenance: inject 320mg (2 x 160mg injections) subcutaneously every 8 weeks ☐ Other: ______	Quantity: ______ Refills: ______
☐ Cibinqo™ (abrocitinib)	☐ 50mg tablet ☐ 100mg tablet ☐ 200mg tablet	☐ Take 100mg PO once daily ☐ Other: ______	Quantity: ______ Refills: ______

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Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______
☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______ Date ______ Supervising Physician Signature: ______ Date ______

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Prescriber's Name ____________
DEA ____________
NPI ____________
Group/Hospital ____________
Address ____________
City, State, ZIP ____________
Phone ____________ Fax ____________
Contact Person ____________ Phone ____________

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ____________

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

☐ L40.0 Psoriasis vulgaris
☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis ____________
☐ Other Diagnosis: ICD-10 Code ______ Description ____________

Date of Diagnosis ____________
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ____________ **Review Date** ____________

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in
Allergies ____________
Lab Data ____________
Prior Therapies ____________
Concomitant Medications ____________
Additional Comments ____________

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength/Form	Directions	Quantity/Refills
☐ Cimzia® (certolizumab pegol)	Cimzia Starter Kit (6 prefilled syringes)	☐ Loading Dose: Inject 400mg SC (2 prefilled syringes) initially and at weeks 2 and 4.	Quantity: 1 Kit Refills: 0
☐ Cimzia® (certolizumab pegol)	☐ 200mg/1 mL Prefilled Syringe ☐ 200mg Vial	Psoriasis Maintenance Dose: ☐ 400mg (given as 2 SC of 200mg each) every other week. ☐ 200mg SC every other week. Psoriatic Arthritis Maintenance Dose: ☐ 200mg SC every other week. ☐ 400mg (given as 2 SC of 200mg each) every 4 weeks. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Cosentyx® (secukinumab)	☐ Sensoready® pen 150mg/mL injection ☐ Prefilled syringe 150mg/mL injection ☐ UnoReady pen 300mg/2mL injection	☐ Loading Dose: Inject 300mg SC at weeks 0, 1, 2, 3 and 4 (0 refills). ☐ Maintenance Dose: Inject 300mg SC every 4 weeks. ☐ Psoriatic Arthritis Loading Dose: (if needed): 150mg SC at weeks 0,1,2,3, and 4 (0 refills). ☐ Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Cyltezo® (adalimumab-adbm)	☐ 40mg/0.8mL Pen Psoriasis Starter Pack (4 pens) ☐ 40mg/0.8mL Pen Hidradenitis Suppurativa Starter Pack (6 pens) ☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL prefilled syringe	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Dupixent® (dupilumab)	☐ 300mg/2ml Prefilled Pen ☐ 300mg/2mL Prefilled Syringe ☐ 200mg/1.14mL Prefilled Syringe	Adults with Atopic Dermatitis or Prurigo Nodularis: ☐ 600mg (two 300mg injections) followed by 300mg Q2W Pediatric Patients with Atopic Dermatitis: **Body Weight** / **Initial Dose** / **Subsequent Doses** ☐ 15 to less than 30 kg / 600mg (two 300mg injections) / 300mg Q4W ☐ 30 to less than 60 kg / 400mg (two 200mg injections) / 200mg Q2W ☐ 60 kg or more / 600mg (two 300mg injections) / 300mg Q2W	Quantity: ______ Refills: ______

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Prescriber's Signature ____________ Date ______ Supervising Physician Signature: ____________ Date ______

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Dermatology Enrollment Form

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Specialty Pharmacy Enrollment Form

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PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______
Address ______
Address 2 ______
City, State, Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ Last Four of SS# ______ Gender ______
Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Group/Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ______

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

☐ L20 Atopic dermatitis
☐ L40.0 Psoriasis vulgaris
☐ L40.2 Acrodermatitis continua
☐ L40.4 Guttate psoriasis
☐ L40.59 Other psoriatic arthropathy
☐ L40.8 Other psoriasis ______
☐ L40.1 Generalized pustular psoriasis
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.54 Psoriatic juvenile arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ Other Diagnosis: ICD-10 Code ______ Description ______

Date of Diagnosis ______
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______
Additional Comments ______

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength/Form	Directions	Quantity/Refills
☐ Enbrel® (etanercept)	☐ 50mg/mL Sureclick™ Autoinjector ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). Avella/Briova does not order the autoinjector. ☐ 25mg/0.5 mL Prefilled Syringe ☐ 25mg/0.5ml single-dose vial	☐ Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing (8 pens, 2 refills). ☐ Psoriasis Maintenance Dose: Inject 50mg SC ONCE a week. ☐ Psoriatic Arthritis Dose: Inject 50mg SC ONCE a week. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Hadlima™ (adalimumab-bwwd)	☐ 40mg/0.4ml prefilled syringe ☐ 40mg/0.8ml prefilled syringe ☐ 40mg/0.4ml PushTouch auto-injector ☐ 40mg/0.8ml PushTouch auto-injector	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Hulio® (adalimumab-fkjp)	☐ 20mg/0.4mL prefilled syringe ☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL pen	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Humira® (adalimumab)	☐ Psoriasis 80mg/0.8 mL and 40mg/0.4 mL Starter Package **Citrate Free**	☐ Psoriasis Induction Dose: Inject 80mg SC on day 1, followed by 40mg SC on day 8, then 40mg every other week.	Quantity: 1 Package Refills: 0
☐ Humira® (adalimumab)	☐ Hidradenitis Suppurativa 80mg/0.8 mL Starter Package **Citrate Free**	☐ Hidradenitis Suppurativa Induction Dose: Inject 160mg SC on Day 1, followed by 80mg two weeks later (Day 15), then 40mg every week starting on Day 29. ☐ Hidradenitis Suppurativa Induction Dose: Inject 160mg SC on Day 1, followed by 80mg two weeks later (Day 15), then 80mg every other week starting on Day 29.	Quantity: 1 Package Refills: 0
☐ Humira® (adalimumab)	☐ 40mg/0.4 mL Pen **Citrate Free** ☐ 40mg/0.4 mL Prefilled Syringe **Citrate Free** ☐ 80mg/0.8 mL Pen **Citrate Free** ☐ Other: ______	☐ Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. ☐ Hidradenitis Suppurativa Maintenance Dose: Inject 40mg SC every week. ☐ Hidradenitis Suppurativa Maintenance Dose: Inject 80mg SC every other week ☐ Other: ______	Quantity: ______ Refills: ______

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Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______ Date ______
Supervising Physician Signature: ______ Date ______

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Optum

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PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______
Address ______
Address 2 ______
City, State, Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ Last Four of SS# ______ Gender ______
Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Group/Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ______

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

☐ L40.0 Psoriasis vulgaris
☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis ______
☐ Other Diagnosis: ICD-10 Code ______

Description ______

Date of Diagnosis ______

Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No

Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______
______
Additional Comments ______
______

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength/Form	Directions	Quantity/Refills
☐ Hyrimoz® (adalimumab-adaz)	☐ 80mg/0.8mL and 40mg/0.4mL Sensoready Pen Psoriasis Starter Kit ☐ 40mg/0.4mL Sensoready Pen ☐ 80mg/0.8mL Sensoready Pen ☐ 40mg/0.4mL prefilled syringe	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Idacio® (adalimumab-aacf)	☐ 40mg/0.8mL Prefilled Pen Plaque Psoriasis Starter Pack ☐ 40mg/0.8ml Prefilled Pen ☐ 40mg/0.8ml prefilled syringe	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week	Quantity: ______ Refills: ______
☐ Ilumya® (tildrakizumab-asmn)	100mg/mL Prefilled Syringe	☐ Psoriasis Induction Dose: Inject one pre-filled syringe (100mg) SC at weeks 0 and 4, then maintenance dosing (2 syringes, no refills). ☐ Psoriasis Maintenance Dose: Inject one pre-filled syringe (100mg) SC every 12 weeks. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Inflectra® (infliximab-dyyb)	100mg vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ Maintenance Dose: Infuse at 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100mg vial Refills: ______
☐ Litfulo (ritlecitinib)	50mg capsule	Take 50mg by mouth one time daily	Quantity: ______ Refills: ______
☐ Olumiant (baricitinib)	☐ 1mg tablet ☐ 2mg tablet ☐ 4mg tablet	Take 2mg by mouth one time daily. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Orencia® (abatacept)	☐ 125mg/mL Prefilled Syringe ☐ 125mg/ml ClickJect Autoinjector ☐ 250mg vial ☐ Other: ______	Inject 125mg SC once weekly. ☐ Other: ______	Quantity: ______ Refills: ______

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☐ L40.59 Other psoriatic arthropathy
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☐ L40.8 Other psoriasis ______
☐ Other Diagnosis: ICD-10 Code ______

Description ______

Date of Diagnosis ______

Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No

Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______

Additional Comments ______

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Drug	Strength/Form	Directions	Quantity/Refills
☐ Otezla® (apremilast)	Titration Starter Pack	Day 1: 10mg PO in the morning. Day 2: 10mg PO in the morning and 10mg PO in the evening. Day 3: 10mg PO in the morning and 20mg PO in the evening. Day 4: 20mg PO in the morning and 20mg PO in the evening. Day 5: 20mg PO in the morning and 30mg PO in the evening. Day 6 and thereafter: 30mg PO twice daily.	Quantity: 1 Pack Refills: 0
☐ Otezla® (apremilast)	30mg tablet	☐ Maintenance Dose: 30mg tablet PO twice daily. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Remicade® (infliximab)	100mg Vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100mg vial Refills: ______
☐ Renflexis® (infliximab-abda)	100mg Vial	☐ Induction Dose: Infuse 5mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100mg vial Refills: ______
☐ Rinvoq® (upadacitinib)	☐ 15mg tablet-Maintenance Dose ☐ 30mg table-Maintenance Dose	☐ Maintenance Dose: Take 15mg PO once daily ☐ Alternative Maintenance Dose: Take 30mg PO once daily	Quantity: ______ Refills: ______
☐ Siliq® (brodalumab)	☐ 210mg/1.5 mL single-dose prefilled syringe	Inject one prefilled syringe (210mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210mg) 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: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)	Quantity: ______ Refills: ______
☐ Simponi® (golimumab)	☐ 50mg/0.5 mL SmartJect® Autoinjector ☐ 50mg/0.5 mL Prefilled Syringe	☐ Psoriatic Arthritis Dose: Inject 50mg SC once a month. ☐ Other: ______	Quantity: ______ Refills: ______

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______ Date ______
Supervising Physician Signature: ______ Date ______

Electronic or digital signatures not accepted.

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Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona or Virginia

Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ____________
Address ____________
Address 2 ____________
City, State, Zip ____________
Home Phone ____________ Alternate Phone ____________
DOB ________ Last Four of SS# ________ Gender ________
Language Preference: ☐ English ☐ Spanish ☐ Other ________

PRESCRIBER INFORMATION

Prescriber's Name ____________
DEA ____________
NPI ____________
Group/Hospital ____________
Address ____________
City, State, ZIP ____________
Phone ____________ Fax ____________
Contact Person ____________ Phone ____________

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ____________

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

☐ L40.0 Psoriasis vulgaris
☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis ____________
☐ Other Diagnosis: ICD-10 Code ________

Description ____________

Date of Diagnosis ____________

Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No

Start Date ____________ **Review Date** ____________

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ________ kg/lbs Height ________ cm/in
Allergies ____________
Lab Data ____________
Prior Therapies ____________
Concomitant Medications ____________

Additional Comments ____________

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength/Form	Dosing	Quantity/Refills
☐ Simponi Aria® (golimumab)	50mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: ☐ Induction Dose: 2mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: 2mg/kg IV infusion over 30 minutes every 8 weeks.	Quantity: ________ # of 50mg vial Refills: ________
☐ Skyrizi® (risankizumab-rzaa)	☐ 150mg/mL prefilled syringe ☐ 150mg/mL prefilled pen	☐ Psoriasis Induction Dose: Inject 150mg SC at Weeks 0 and 4, then maintenance dosing (0 refills). ☐ Psoriasis Maintenance Dose: Inject 150mg SC every 12 weeks. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Sotyktu® (deucravacitinib)	6mg tablet	☐ Take one 6mg tablet PO once daily. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Stelara® (ustekinumab)	☐ 45mg/0.5 mL prefilled syringe ☐ 90mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45mg SC initially and 4 weeks later (2 syringes, 0 refills). ☐ For patients weighing >100 kg (220 lbs): Inject 90mg SC initially and 4 weeks later (2 syringes, 0 refills). ☐ Maintenance Dose: Inject 45mg SC every 12 weeks. ☐ Maintenance Dose: Inject 90mg SC every 12 weeks. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Taltz® (ixekizumab)	☐ 80mg Single Dose Autoinjector ☐ 80mg Single Dose Prefilled Syringe	Psoriasis Induction Dosing: ☐ Starting Dose: Inject SC two 80mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80mg injection every 2 weeks (weeks 2-10). ☐ Final Induction Dose: Inject SC one 80mg injection (week 12). Psoriatic Arthritis Induction Dosing: ☐ Induction Dose: 160mg SC at week 0.	☐ 8 pens/syringes ☐ 2 pens/syringes
		☐ Maintenance Dose: 80mg SC once every 4 weeks.	Quantity: ________ Refills: ________

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Ship to: ☐ Patient ☐ Office ☐ Other ____________ Date ____________ Needs by Date ____________

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Prescriber's Signature ____________ Date ________ Supervising Physician Signature: ____________ Date ________

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Optum

Dermatology Enrollment Form

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Specialty Pharmacy Enrollment Form

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Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______
Address ______
Address 2 ______
City, State, Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ Last Four of SS# ______ Gender ______
Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Group/Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

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Diagnosis – Please include diagnosis name with ICD-10 code

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☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
☐ L40.4 Guttate psoriasis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ L73.2 Hidradenitis suppurativa
☐ L40.8 Other psoriasis ______
☐ Other Diagnosis: ICD-10 Code ______

Description ______

Date of Diagnosis ______

Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No

Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______
Additional Comments ______

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Form	Directions	Quantity/Refills
☐ Tremfya® (guselkumab)	☐ 100mg/mL prefilled syringe ☐ 100mg/ml One-Press Injector	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills). ☐ Maintenance Dose: Inject 100mg SC once every 8 weeks.	Quantity: ______ Refills: ______
☐ Xeljanz® (tofacitinib)	☐ 5mg Tablet ☐ 11mg XR Tablet	☐ Take one 5mg tablet PO twice daily. ☐ Take one 11mg tablet PO once daily. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Yuflyma™ (adalimumab-aaty)	☐ 40mg/0.4mL prefilled syringe ☐ 40mg/0.4mL autoinjector	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Yusimry™ (adalimumab-aqvh)	☐ 40mg/0.8mL prefilled syringe ☐ 40mg/0.8mL auto-injector	☐ Psoriasis Initiation: Inject 80mg SQ on Day 1, then 40mg on Day 8, then 40mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80mg SQ on Day 15 ☐ HS maintenance: 40mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80mg QV every other week starting on Day 29	Quantity: ______ Refills: ______
☐ Other	☐ Other: ______	☐ Other: ______	Quantity: ______ Refills: ______

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Supervising Physician Signature: ______ Date ______

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