OPTUM®

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

Dermatology Enrollment Form

Specialty Pharmacy Enrollment Form ✂ 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 _____
☐ L20 Atopic dermatitis
☐ 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
☐ Cimzia®	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®	☐ 200 mg/1 mL Prefilled Syringe ☐ 200 mg Vial	Psoriasis Maintenance Dose: ☐ 400 mg (given as 2 SC of 200 mg each) every other week. ☐ 200 mg SC every other week. Psoriatic Arthritis Maintenance Dose: ☐ 200 mg SC every other week. ☐ 400 mg (given as 2 SC of 200 mg each) every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Cosentyx®	☐ Sensoready® pen 150 mg/mL injection ☐ Prefilled syringe 150 mg/mL injection	☐ Psoriasis Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4 (0 refills). ☐ Psoriasis Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks. ☐ Psoriatic Arthritis Loading Dose: (if needed): 150 mg SC at weeks 0,1,2,3, and 4 (0 refills). ☐ Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Dupixent®	☐ 300mg/2ml Prefilled Pen ☐ 300mg/2mL Prefilled Syringe ☐ 200mg/1.14mL Prefilled Syringe	Adults: ☐ 600 mg (two 300 mg injections) followed by 300 mg Q2W Pediatric Patients: **Body Weight** / **Initial Dose** / **Subsequent Doses** ☐ 15 to less than 30 kg — 600 mg (two 300 mg injections) — 300 mg Q4W ☐ 30 to less than 60 kg — 400 mg (two 200 mg injections) — 200 mg Q2W ☐ 60 kg or more — 600 mg (two 300 mg injections) — 300 mg Q2W	Quantity: _____ Refills: _____
☐ Enbrel®	☐ 50 mg/mL Sureclick™ Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ 50 mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). Avella/Briova does not order the autoinjector. ☐ 25 mg/0.5 mL Prefilled Syringe ☐ 25mg/0.5ml single-dose vial	☐ Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing (8 pens, 2 refills). ☐ Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week. ☐ Psoriatic Arthritis Dose: Inject 50 mg SC ONCE a week. ☐ Other: _____	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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☐ 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

☐ Humira®	☐ Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	☐ Psoriasis Induction Dose: Inject 80 mg SC on day 1, followed by 40 mg SC on day 8, then 40 mg every other week.	Quantity: 1 Package Refills: 0
☐ Humira®	☐ Hidradenitis Suppurativa 80 mg/0.8 mL Starter Package **Citrate Free**	☐ Hidradenitis Suppurativa Induction Dose: Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 40mg on Day 29 and subsequent doses.	Quantity: 1 Package Refills: 0
☐ Humira®	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL Prefilled Syringe **Citrate Free** ☐ Other: _____	☐ Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. ☐ Hidradenitis Suppurativa Maintenance Dose: Inject 40 mg SC every week. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Ilumya™	100 mg/mL Prefilled Syringe	☐ Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing (2 syringes, no refills). ☐ Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Inflectra®	100 mg vial	☐ Induction Dose: Infuse 5 mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ Maintenance Dose: Infuse at 5 mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
☐ Orencia®	☐ 125 mg/mL Prefilled Syringe ☐ 125mg/ml ClickJect Autoinjector ☐ 250 mg vial ☐ Other: _____	Inject 125 mg SC once weekly. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Otezla®	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.	Quantity: 1 Pack Refills: 0
☐ Otezla®	30 mg tablet	☐ Maintenance Dose: 30 mg tablet PO twice daily. ☐ Other: _____	Quantity: _____ Refills: _____

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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

☐ Remicade®	100 mg Vial	☐ Induction Dose: Infuse 5 mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5 mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
☐ Renflexis®	100 mg Vial	☐ Induction Dose: Infuse 5 mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). ☐ Maintenance Dose: Infuse 5 mg/kg (Dose = _____mg) IV every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
☐ Siliq®	☐ 210 mg/1.5 mL single-dose prefilled syringe	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: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)	Quantity: _____ 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. ☐ Other: _____	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 (0 refills). ☐ Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks.	Quantity: _____ # of 50 mg vial Refills: _____
☐ Skyrizi®	75 mg/0.83 mL prefilled syringe	☐ Psoriasis Induction Dose: Inject 150 mg (two injections) SC at Weeks 0 and 4, then maintenance dosing (0 refills). ☐ Psoriasis Maintenance Dose: Inject 150mg (two injections) SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Stelara®	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later (2 syringes, 0 refills). ☐ For patients weighing >100 kg (220 lbs): Inject 90 mg 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: _____

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Allergies _____
Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments _____
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ Taltz®	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose Prefilled Syringe	Psoriasis Induction Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). ☐ Final Induction Dose: Inject SC one 80 mg 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: _____
☐ Tremfya®	☐ 100 mg/mL prefilled syringe ☐ 100 mg/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®	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily. ☐ Take one 11 mg tablet PO once daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Other	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

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