



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

Dermatology Enrollment Form

Page 1 of 4 (A-G)

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

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
<input type="checkbox"/> Cimzia®	Cimzia Starter Kit (6 prefilled syringes)	<input type="checkbox"/> Loading Dose: Inject 400mg SC (2 prefilled syringes) initially and at weeks 2 and 4.	Quantity: 1 Kit Refills: 0
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200 mg/1 mL Prefilled Syringe <input type="checkbox"/> 200 mg Vial	Psoriasis Maintenance Dose: <input type="checkbox"/> 400 mg (given as 2 SC of 200 mg each) every other week. <input type="checkbox"/> 200 mg SC every other week. Psoriatic Arthritis Maintenance Dose: <input type="checkbox"/> 200 mg SC every other week. <input type="checkbox"/> 400 mg (given as 2 SC of 200 mg each) every 4 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> Sensoready® pen 150 mg/mL injection <input type="checkbox"/> Prefilled syringe 150 mg/mL injection	<input type="checkbox"/> Psoriasis Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4 (0 refills). <input type="checkbox"/> Psoriasis Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks. <input type="checkbox"/> Psoriatic Arthritis Loading Dose: (if needed): 150 mg SC at weeks 0,1,2,3, and 4 (0 refills). <input type="checkbox"/> Psoriatic Arthritis Maintenance Dose: 150mg SC every 4 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300mg/2ml Prefilled Pen <input type="checkbox"/> 300mg/2mL Prefilled Syringe <input type="checkbox"/> 200mg/1.14mL Prefilled Syringe	Adults: <input type="checkbox"/> 600 mg (two 300 mg injections) followed by 300 mg Q2W Pediatric Patients: Body Weight Initial Dose Subsequent Doses <input type="checkbox"/> 15 to less than 30 kg 600 mg (two 300 mg injections) 300 mg Q4W <input type="checkbox"/> 30 to less than 60 kg 400 mg (two 200 mg injections) 200 mg Q2W <input type="checkbox"/> 60 kg or more 600 mg (two 300 mg injections) 300 mg Q2W	Quantity: _____ Refills: _____
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50 mg/mL Sureclick™ Autoinjector <input type="checkbox"/> 50 mg/mL Prefilled Syringe <input type="checkbox"/> 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. <input type="checkbox"/> 25 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 25mg/0.5ml single-dose vial	<input type="checkbox"/> 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). <input type="checkbox"/> Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week. <input type="checkbox"/> Psoriatic Arthritis Dose: Inject 50 mg SC ONCE a week. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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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PATIENT INFORMATION

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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

<input type="checkbox"/> Humira®	<input type="checkbox"/> Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package Citrate Free	<input type="checkbox"/> 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
<input type="checkbox"/> Humira®	<input type="checkbox"/> Hidradenitis Suppurativa 80 mg/0.8 mL Starter Package Citrate Free	<input type="checkbox"/> 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
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg/0.4 mL Pen Citrate Free <input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe Citrate Free <input type="checkbox"/> Other: _____	<input type="checkbox"/> Psoriasis/Psoriatic Arthritis Maintenance Dose: Inject 40mg SC every other week. <input type="checkbox"/> Hidradenitis Suppurativa Maintenance Dose: Inject 40 mg SC every week. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ilumya™	100 mg/mL Prefilled Syringe	<input type="checkbox"/> Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing (2 syringes, no refills). <input type="checkbox"/> Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Inflectra®	100 mg vial	<input type="checkbox"/> Induction Dose: Infuse 5 mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: Infuse at 5 mg/kg (Dose = _____mg) IV every 8 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125 mg/mL Prefilled Syringe <input type="checkbox"/> 125mg/ml ClickJect Autoinjector <input type="checkbox"/> 250 mg vial <input type="checkbox"/> Other: _____	Inject 125 mg SC once weekly. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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
<input type="checkbox"/> Otezla®	30 mg tablet	<input type="checkbox"/> Maintenance Dose: 30 mg tablet PO twice daily. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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Product Substitution permitted Dispense as Written

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

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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
 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

<input type="checkbox"/> Remicade®	100 mg Vial	<input type="checkbox"/> Induction Dose: Infuse 5 mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). <input type="checkbox"/> Maintenance Dose: Infuse 5 mg/kg (Dose = _____mg) IV every 8 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
<input type="checkbox"/> Renflexis®	100 mg Vial	<input type="checkbox"/> Induction Dose: Infuse 5 mg/kg (Dose = _____mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter (0 refills). <input type="checkbox"/> Maintenance Dose: Infuse 5 mg/kg (Dose = _____mg) IV every 8 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
<input type="checkbox"/> Siliq®	<input type="checkbox"/> 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: _____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50 mg/0.5 mL SmartJect® Autoinjector <input type="checkbox"/> 50 mg/0.5 mL Prefilled Syringe	<input type="checkbox"/> Psoriatic Arthritis Dose: Inject 50 mg SC once a month. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi Aria®	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: <input type="checkbox"/> Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter (0 refills). <input type="checkbox"/> Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks.	Quantity: _____ # of 50 mg vial Refills: _____
<input type="checkbox"/> Skyrizi®	<input type="checkbox"/> 150 mg/mL prefilled syringe <input type="checkbox"/> 150 mg/mL prefilled pen	<input type="checkbox"/> Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing (0 refills). <input type="checkbox"/> Psoriasis Maintenance Dose: Inject 150mg SC every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<input type="checkbox"/> For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later (2 syringes, 0 refills). <input type="checkbox"/> For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later (2 syringes, 0 refills). <input type="checkbox"/> Maintenance Dose: Inject 45mg SC every 12 weeks. <input type="checkbox"/> Maintenance Dose: Inject 90mg SC every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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 Product Substitution permitted Dispense as Written
Prescriber's Signature _____ Date _____ Supervising Physician Signature: _____ Date _____
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PATIENT INFORMATION

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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

<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose Prefilled Syringe	<p>Psoriasis Induction Dosing: <input type="checkbox"/> Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. <input type="checkbox"/> Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). <input type="checkbox"/> Final Induction Dose: Inject SC one 80 mg injection (week 12). Psoriatic Arthritis Induction Dosing: <input type="checkbox"/> Induction Dose: 160mg SC at week 0.</p> <hr/> <input type="checkbox"/> Maintenance Dose: 80mg SC once every 4 weeks.	<input type="checkbox"/> 8 pens/syringes <input type="checkbox"/> 2 pens/syringes Quantity: _____ Refills: _____
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> 100 mg/mL prefilled syringe <input type="checkbox"/> 100 mg/ml One-Press Injector	<input type="checkbox"/> Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills). <input type="checkbox"/> Maintenance Dose: Inject 100mg SC once every 8 weeks.	Quantity: _____ Refills: _____
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Take one 5 mg tablet PO twice daily. <input type="checkbox"/> Take one 11 mg tablet PO once daily. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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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