DOC'S PHARMACY
SPECIALTY CARE SERVICES

PSORIASIS SPECIALTY CARE PROGRAM

Phone: **855-362-7111** • Fax: **855-362-7171**

KloudScript
Specialty Care *Redefined*

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: _____

❑ 696.1 Psoriasis
❑ 696.0 Psoriatic Arthritis
❑ 705.83 Hidradenitis Suppurativa
❑ Other: _____

TB Test: ❑ Positive ❑ Negative Date: _____

Assessment: ❑ Moderate ❑ Mod to Severe ❑ Severe

____% BSA affected

❑ Hands ❑ Scalp ❑ Feet ❑ Groin ❑ Nails

Serious or active infection present? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
History of malignancy? ❑ Yes ❑ No
History of MS or other demyelinating disease? ❑ Yes ❑ No
New onset CHF or worsening CHF? ❑ Yes ❑ No
Contraindications for oral agent(s) or phototherapy? ❑ No ❑ Yes _____

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

4 PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
❑ COSENTYX™	**To order Cosentyx, please complete the Novartis Cosentyx form with Doc's Pharmacy designated as the specialty pharmacy of choice at the bottom of page 5 and fax directly to us at the number above.**			
❑ 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 ❑ Other: _____	❑ **Maintenance:** Inject 50mg SC once a week ❑ Other: _____	4	
❑ 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 ❑ 40mg/0.8ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC every other week ❑ 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 ❑ 40mg/0.8ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC every week	4	
❑ 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	
❑ SIMPONI® (for PsA)	❑ 50mg/0.5ml Smartject Injector ❑ 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*			
❑ _____	_____	_____		

5 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 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: _____

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.