Optum

Dermatology Enrollment Form

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

Specialty Pharmacy Enrollment Form — Please detach before submitting to a pharmacy – tear here — **This form is not a valid prescription in Arizona or Virginia**

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: _____

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☐ L40.1 Generalized pustular psoriasis
☐ L40.2 Acrodermatitis continua
☐ L40.3 Pustulosis palmaris et plantaris
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Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

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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® (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)	Starter Kits: ☐ 40mg/0.4mL Pen Psoriasis Starter Pack (4 pens) ☐ 40mg/0.8mL Pen Psoriasis Starter Pack (4 pens) ☐ 40mg/0.4mL Pen Hidradenitis Suppurativa Starter Pack (6 pens) ☐ 40mg/0.8mL Pen Hidradenitis Suppurativa Starter Pack (6 pens) Maintenance: ☐ 40mg/0.4mL Pen ☐ 40mg/0.8mL Pen ☐ 40mg/0.4mL prefilled syringe ☐ 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: _____

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☐ L40.59 Other psoriatic arthropathy
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☐ 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	Dose & Directions	Qty/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: _____
☐ Ebglyss™ (lebrikizumab-lbkz)	☐ 250 mg/2mL Pen ☐ 250mg/2mL prefilled syringe	☐ Atopic Dermatitis Initiation: Inject 500mg (2 pens) SC at week 0 and week 2, then inject 250mg (1 pen) SC every 2 weeks until week 16 or later. ☐ Atopic Dermatitis Maintenance: Inject 250mg (1 pen) SC every 4 weeks.	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: _____

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

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☐ L40.0 Psoriasis vulgaris
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☐ L40.2 Acrodermatitis continua
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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

Medication	Strength	Dose & Directions	Qty/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: _____
☐ 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: _____

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Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Litfulo (ritlecitinib)	50mg capsule	Take 50mg by mouth one time daily	Quantity:_____ Refills: _____
☐ Nemluvio® (nemolizumab-ilto)	30 mg/0.49mL Pen	☐ Initiation: Inject 60mg (2 pens) SC at week 0. ☐ Adults < 90kg Maintenance: Inject 30mg (1 pen) SC every 4 weeks. ☐ Adults ≥ 90kg Maintenance: Inject 60mg (2 pens) SC every 4 weeks.	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: _____
☐ 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: _____

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Dermatology Enrollment Form

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

☐ 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	Dose & Directions	Qty/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: _____
☐ Simlandi® (adalimumab-ryvk)	40 mg/0.4mL auto-injector	☐ Psoriasis Initiation: Inject 80 mg SQ on Day 1, then 40 mg on Day 8, then 40 mg every other week ☐ Psoriasis/Psoriatic Arthritis Maintenance: Inject 40 mg SQ every other week ☐ Hidradenitis suppurativa (HS) induction: Inject 160mg SQ on Day 1, then 80 mg SQ on Day 15 ☐ HS maintenance: 40 mg SQ every week starting on Day 29 ☐ Alternate HS maintenance: 80 mg QV every other week starting on Day 29	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: _____
☐ 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: _____

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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 _____

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Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

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Contact Person _____ Phone _____

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

Prior Authorization Reference number: _____

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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	Dose & Directions	Qty/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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Prescriber's Name _____

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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
☐ 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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