Star Discount Pharmacy specialty care

urac ACCREDITED Specialty Pharmacy Expires 12/01/2021

ACHC

Pediatric Immunology

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name: _____ DOB: _____ Gender: ○M ○F

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____ Alt. Phone: _____

Email: _____ Ht: ____ Wt: ____ Care Giver: _____ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: _____ Address: _____City: _____

State: _____ Zip: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ **ICD-10:** _____ **Other:** _____ **TB Test:** ○Positive ○Negative Date: _____

LFT: ALT: _____ AST: _____ Date: _____ **Assessment:** ○Moderate ○Mod to Severe ○Severe ____**% BSA Affected**

○Scalp ○Face ○Chest ○Arms ○Hands ○Nails ○Back ○Groin ○Buttocks ○Legs ○Other _____ **ISGA or EASI** _____

Patient also taking methotrexate? ○Yes ○No

Serious or active infection present? ○Yes ○No

Hep B ruled out or treatment started? ○Yes ○No

Does patient have latex allergy? ○Yes ○No

Injection Training: ○Pharmacist to Provide Training
○Patient Trained in MD Office
○Manufacturer Nurse Support
○To Be Administered By a HCP

Product Delivery: ○Patient's Home
○Physician's Office ○Pharmacy to Coordinate

Prior Failed Treatments	Drug Name	Length of Treatment
○5-ASA		
○Biologics		
○Corticosteroids		
○Immunosuppressants		
○Methotrexate		
○NSAIDS		
○Surgery		
○Topical/Oral Antibiotics		
○UVA ○UVB		
○Other		

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Ref
○Humira	**Pediatric Crohn's Disease** ○Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml ○Pediatric Crohn's Starter Pack: 80mg/0.8ml ○20mg/0.2ml Prefilled Syringe ○40mg/0.4ml Pen ○40mg/0.4ml Prefilled Syringe	**Induction Dose:** ○ **37 lbs to <88 lbs:** Inject one 80mg pen SC on day 1, then one 40mg pen SC on day 15	2	0
		○ **>88 lbs:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ○ **>88 lbs:** Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15	3	0
		Maintenance Dose: ○ **37 lbs to <88 lbs:** Inject 20mg SC every other week ○ **>88 lbs:** Inject 40mg SC every other week	2	
○Stelara	**Pediatric Plaque Psoriasis** ○45mg/0.5ml Prefilled Syringe ○45mg/0.5ml Single-Dose Vial ○90mg/ml Prefilled Syringe	**Induction Dose:** ○ **<60kg:** Inject 0.75mg/kg SC at week 0	1	0
		○ **60-100kg:** Inject 45mg SC at week 0	1	0
		○ **>100kg:** Inject 90mg SC at week 0		0
		Maintenance: ○ <60kg: Inject 0.75mg/kg at week 4, then every 12 weeks thereafter ○ 60-100kg: Inject 45mg SC at week 4, then every 12 weeks thereafter ○ >100kg: Inject 90mg SC at week 4, then every 12 weeks thereafter		
○Taltz	**Pediatric Plaque Psoriasis** ○80mg/ml Single-Dose Prefilled Autoinjector ○80mg/ml Single-Dose Prefilled Syringe *20mg and 40mg doses for patients weighing <=50kg (110lb) must be prepared and administered by a qualified healthcare professional.*	**Induction Dose:** ○ >50kg: Inject 160mg SC (two 80mg injections) at week 0	2	0
		○ 25 to 50kg: Inject 80mg SC at week 0	1	
		○ <25kg: Inject 40mg SC at week 0		
		Maintenance: ○ >50kg: Inject 80mg SC at week 4 and every 4 weeks thereafter ○ 25-50kg: Inject 40mg SC at week 4 and every 4 weeks thereafter ○ <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature:_____ Date: _____

Substitution Permitted **Dispense as Written**

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.

Star Discount Pharmacy specialty care

Pediatric Immunology

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name: _____ DOB: _____ Gender: ○M ○F

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____ Alt. Phone: _____

Email: _____ Ht: ____ Wt: ____ Care Giver: _____ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: _____ Address: _____ City: _____

State: _____ Zip: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ **ICD-10:** _____ **Other:** _____ **TB Test:** ○Positive ○Negative Date: _____

LFT: ALT: _____ AST: _____ Date: _____ **Assessment:** ○Moderate ○Mod to Severe ○Severe ____**% BSA Affected**

○Scalp ○Face ○Chest ○Arms ○Hands ○Nails ○Back ○Groin ○Buttocks ○Legs ○Other _____ **ISGA or EASI** _____

Patient also taking methotrexate? ○Yes ○No

Serious or active infection present? ○Yes ○No

Hep B ruled out or treatment started? ○Yes ○No

Does patient have latex allergy? ○Yes ○No

Injection Training: ○Pharmacist to Provide Training
○Patient Trained in MD Office
○Manufacturer Nurse Support
○To Be Administered By a HCP

Product Delivery: ○Patient's Home
○Physician's Office ○Pharmacy to Coordinate

Prior Failed Treatments	Drug Name	Length of Treatment
○5-ASA		
○Biologics		
○Corticosteroids		
○Immunosuppressants		
○Methotrexate		
○NSAIDS		
○Surgery		
○Topical/Oral Antibiotics		
○UVA ○UVB		
○Other		

Prescription Information

Medication	Dosage & Strength	Direction	Qty	Ref
○Dupixent	**Pediatric Atopic Dermatitis** ○300mg/2ml Prefilled Syringe ○200mg/1.14ml Prefilled Syringe ○300mg/2ml Prefilled Pen *(only for 12 years and older)*	**Induction Dose:** ○ **≥ 60 kg:** Inject 600mg SC (two 300mg injections) ○ **30 to <60 kg:** Inject 400mg SC (two 200mg injections) ○ **15 to <30 kg:** Inject 600mg SC (two 300mg injections)	2	0
		Maintenance Dose: ○ ≥ 60 kg: Inject 300mg SC every other week ○ 30 to <60 kg: Inject 200mg SC every other week ○ 15 to <30 kg: Inject 300mg SC every 4 weeks		
○Humira	**Hidradenitis Suppurativa** ○ Adolescent Hidradenitis Suppuritiva 80mg/0.8ml and 40mg/0.4ml Starter Pack ○ Adolescent Hidradenitis Suppurativa 40mg/0.4ml Starter Package ○ Hidradenitis Suppurativa 80mg/0.8ml Starter pack ○ Hidradenitis Suppurativa 40mg/0.4ml Starter pack ○ 40mg/0.4ml Pen ○ 40mg/0.4ml Prefilled Syringe	**Induction Dose:** ○ **Adolescents 12 years and older 66 lbs to <132 lbs:** Inject 80mg SC on day 1, then 40mg SC on day 8 and every other week thereafter ○ **Adolescents 12 years and older >132 lbs:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 ○ **Adolescents 12 years and older >132 lbs:** Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15	3 4 3 6	0 0 0 0
		Maintenance Dose: ○ **Adolescents 12 years and older 66 lbs to <132 lbs**: Inject 40mg every other week ○ **Adolescents 12 years and older >132 lbs**: Inject 40mg on day 29 then inject 40mg every week	2	
○Humira	**Juvenile Idiopathic Arthritis + Pediatric Uveitis** ○10mg/0.1ml Prefilled Syringe ○20mg/0.2ml Prefilled Syringe ○40mg/0.4ml Pen ○40mg/0.4ml Prefilled Syringe	○ **22 lbs to <33 lbs**: Inject 10mg SC every other week ○ **33 lbs to <66 lbs**: Inject 20mg SC every other week ○ **≥66 lbs**: Inject 40mg SC every other week	2	
○_____	○_____	○ _____		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature_____ Date: _____

Substitution Permitted **Dispense as Written**

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.