

Pediatric Immunology

Call: (877) 883-1392 Fax: (256) 429-2221

| SC on day 15 O Pediatric Crohn's Starter Pack: 80mg/0.8ml O Pediatric Crohn's Starter Pack: 80mg/0.8ml O 20mg/0.2ml Prefilled Syringe O 40mg/0.4ml Prefilled Syringe O 40mg/0.4ml Prefilled Syringe O 40mg/0.4ml Prefilled Syringe O 45mg/0.5ml Prefilled Syringe O 45mg/0.5ml Single-Dose Vial O 90mg/ml Prefilled Syringe O 45mg/0.5ml Single-Dose Vial O 90mg/ml Prefilled Syringe O 45mg/0.5ml Single-Dose Vial O 90mg/ml Prefilled Syringe O 80mg/ml Single-Dose Vial O 90mg/ml Prefilled Syringe O 80mg/ml Single-Dose Prefilled | Dationt Info | rmation | Namai | | | DOD | | Condon OM | Or Last 4 of SSN: | | |
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| Email: Ht. Wit. Care Giver: Allergies: ONo Known O See Attached Charts Prescriber Information: Name; Address: Git; Git; State: Zip; NPI; Phone; Fax; Office Contact: Statement of Medical Necessity (Please Attach All Medical Documentation) | | | | | | | | | | | |
| Prescription Information: Name: | | | | | | | | | | | |
| Statement of Medical Necessity (Please Attach All Medical Documentation) Date of Diagnosis: | | | | | | | | | | | |
| Statement of Medical Necessity (Please Attach All Medical Documentation) | Prescriber I | nformation | : Name: | | | Ac | ddress:_ | | City: | | |
| Date of Dalganosis: ICD-10: | State:Z | <u>'ip:</u> | NPI: | | | Phone: | | Fax <u>:</u> | Office Contact: | | |
| Obten Street Desire De | | | | | | | | | | | |
| AST: | | | | | | | | | | | |
| Scalp Face Chest Carms Chands Challs Chands | Date of Diagno | osis: | ICD-10 | D: | | Other: | | FB Test: ○ Positive ○ | Negative Date: | | |
| Patient also taking methotrexate? Serious or active infection present? Wes O'No Des patient thave latex allergy? Injection Training: O'Pharmacist to Provide Training: O'Patient Training in MD Office O Manufacturer Nurse Support O'To Be Administered By a HCP Product Delivery: O'Patient Training in MD Office O Manufacturer Nurse Support O'To Be Administered By a HCP Product Delivery: O'Patient's Home O'Physician's Office O Pharmacy to Coordinate O'READIS O'READIS O'READIS O'READIS | | | | | | | | · · | | | |
| Serious or active infection present? O'res O'No Hep B ruled out or treatment started? Yes O'No O'S-ASA O'S-Bollogics O'S-Bollo | ⇒Scalp ⊝Fac | e OChest OA | Arms OHan | nds ONails | ○Bac | ck OGroin OButtocks (| OLegs C | Other | ISGA or EAS | I | |
| Serious or active infection present? Yes ONo OS-ASA OS-ASA OS | Patient also t | aking methot | rexate? | O yes C | No | Prior Failed Treatm | ents | Drug Name | Length of | Treatmer | nt |
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| Or to Be Administered By a HCP Product Delivery: ○Patient's Home OPhysician's Office O Pharmacy to Coordinate Prescription Information Medication Medication Pediatric Crohn's Disease O Pediatric Crohn's Disease O Pediatric Crohn's Starter Pack: 80mg/0.8ml O 20mg/0.2ml Prefilled Syringe O40mg/0.4ml Prefilled Syringe O40mg/0.4ml Prefilled Syringe O40mg/0.4ml Prefilled Syringe O40mg/0.5ml Prefilled Syringe O45mg/0.5ml Prefilled Syringe O5telara Pediatric Plaque Psoriasis O 85mg/ml Single-Dose Prefilled Autoinjector O 80mg/ml Single-Dose Prefilled Autoingietor O 80mg/ml Single-Dose | | _ | | | | ONSAIDS | | | | | |
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| O Pediatric Crohn's Starter Pack: 80mg/0.2ml Prefilled Syringe | | | | | | | | | | | |
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| OStelara Pediatric Plaque Psoriasis | | ○40mg/0.4ml Prefilled Syringe | | | Ma | Maintenance Dose: | | | | | |
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| O\$\text{Stelara}\$ \[\begin{array}{c ccccccccccccccccccccccccccccccccccc | | | | | 0 | >88 lbs: Inject 40mg S | C every | other week | | | |
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| O 80mg/ml Single-Dose Prefilled Syringe Maintenance: O >50kg: Inject 40mg SC at week 0 Maintenance: O >50kg: Inject 80mg SC at week 4 and every 4 weeks thereafter O 25-50kg: Inject 40mg SC at week 4 and every 4 weeks thereafter O 25-50kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 week | | | | | | | | | | | 0 |
| O Taltz Syringe 20mg and 40mg doses for patients weighing <=50kg (110lb) must be prepared and administered by a qualified healthcare professional. Prescriber Signature (□ authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs) Signature: Substitution Permitted Dispense as Written | | | | | | | | | | | |
| 20mg and 40mg doses for patients weighing <=50kg (110lb) must be prepared and administered by a qualified healthcare professional. O >50kg: Inject 80mg SC at week 4 and every 4 weeks thereafter O 25-50kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter O <25kg: Inject 20mg S | | | | | _ | | | | | | |
| 20mg and 40mg doses for patients weighing <=50kg (110lb) must be prepared and administered by a qualified healthcare professional. Prescriber Signature (Lauthorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs) Signature: Substitution Permitted Dispense as Written | | | | | _ | | | | | | |
| weighing <=50kg (110lb) must be prepared and administered by a qualified healthcare professional. O <25kg: Inject 20mg SC at week 4 and every 4 weeks thereafter Prescriber Signature (Lauthorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs) Signature: Substitution Permitted Dispense as Written | | | | | | O 25-50kg: Inject 40mg SC at week 4 and every 4 weeks thereafter | | | | | |
| qualified healthcare professional. Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs) Signature: Substitution Permitted Dispense as Written | | | | | | | | | | | |
| 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: Date: Date: Dispense as Written | | quanjica ricuit | | | | | | | | † | |
| Signature: Date: Date: Date: Dispense as Written | | | | | | | | | | | |
| Signature: Date: Date: Date: Dispense as Written | Prescriber S | ignature name | thorize pharmacy t | to act as my design | ee for ini | tiating and coordinating insurance o | rior authoriz | ations, nursing services and nations | ssistance programs) | | |
| Substitution Permitted Dispense as Written | | -O | onice prioritiacy t | | | | | | and programs, | | |
| · · | | Substitution I | Permitted | | 0.10 | | Written | | | | |
| | | | | will be determ | ined b | • | | | nd the terms of the patient' | s coverage | among |

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Pediatric Immunology

| Patien | nt Information: Name: | | DOB: | Gender: 🔿 🖺 | иOF | | | |
|-----------|--|------------------|---|-----------------------------------|-------------------------|--------------------|----------|----|
| Address | s: City: | | State: Zip: | Phone: | Alt | t. Phone: | | _ |
| Email:_ | Ht:Wt:Ca | re Giver:_ | | Allergies: ON | o Known O Se | ee Attached Charts | i | |
| Prescr | riber Information: Name: | | Address: | | (| City: | | |
| State: | Zip:NPI: | F | Phone: | Fa <u>x:</u> | Office_ | Contact: | | |
| Statem | nent of Medical Necessity (Please Attach All Me | edical Docu | mentation) | | | | | _ |
| | Diagnosis: ICD-10: | | | B Test: O Positive | ONegative Date | e: | | _ |
| LFT: ALT | T:AST:Date: Assess i | ment: ON | noderate ⊖Mod to Sev | vere OSevere | % BSA Af | ffected | | |
| | O Face OChest OArms OHands ONails OBa | | | | | | | |
| Patien | nt also taking methotrexate? Yes O No | Prior | Failed Treatments | Drug Na | ame | Length of Treat | men | t |
| | is or active infection present? Yes No | 0-10 | | 2.08.0 | | | | ÷ |
| | ruled out or treatment started? O Yes ONo | | | | | | | _ |
| - | patient have latex allergy? OYes ONo | <u> </u> | costeroids | | | | | _ |
| • | n Training: OPharmacist to Provide Training | | unosuppressants | | | | | _ |
| injection | OPatient Trained in MD Office | OMeth | otrexate | | - | | | |
| | OManufacturer Nurse Support | ONSAII | AIDS | | | | | |
| | OTo Be Administered By a HCP | OSurge | ery | | | | | _ |
| Product | t Delivery : OPatient's Home | ОТоріс | al/Oral Antibiotics | | | | | |
| | cian's Office O Pharmacy to Coordinate | QUVA | Q UVB | | | | | |
| OPTIVSIC | ciall's Office O Filatiliacy to Coordinate | O0the | r | | | | | |
| | to to form of the | | | | | | | |
| | ion Information | | ·· | | | | | Τ. |
| | Dosage & Strength | | Direction | | | | Qty 2 | - |
| ODupixent | | | Induction Dose: ○ ≥ 60 kg: Inject 600mg SC (two 300mg injections) | | | | | (|
| | O 300mg/2ml Prefilled Syringe 200mg/1.14ml Prefilled Syringe | | ○ 30 to <60 kg: Inject | | • | | | |
| | 300mg/2ml Prefilled Pen | | ○ 15 to <30 kg: Inject | • , | | | | |
| | (only for 12 years and older) | = | Maintenance Dose: | | | | | + |
| | | | | | | | | |
| | | | 30 to <60 kg: Inject 2 | | | | | |
| OHumira | | | 15 to <30 kg: Inject 3 | 300mg SC every 4 wee | :KS | | <u> </u> | +_ |
| JHumira | Hidradenitis Suppurativa O Adolescent Hidradenitis Suppuritiva 80mg/0.8ml | land | | rs and older 66 lbs to | <122 lbc: Inject 0 | Oma CC on day 1 | 3 | 0 |
| | 40mg/0.4ml Starter Pack | iaiiu | Adolescents 12 years and older 66 lbs to <132 lbs: Inject 80mg SC on day 1, then 40mg SC on day 8 and every otherweek thereafter Adolescents 12 years and older >132 lbs: Inject two 80mgpens SC on day 1, then one 80mg pen SC on day 15 Adolescents 12 years and older >132 lbs: Inject one 80mgpen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 | | | | | C |
| | O Adolescent Hidradenitis Suppurativa | | | | | | | C |
| | 40mg/0.4ml Starter Package | | | | | | | ' |
| | O Hidradenitis Suppurativa 80mg/0.8ml Starterpack | | | | | | | 0 |
| | O Hidradenitis Suppurativa 40mg/0.4ml Starterpack 40mg/0.4ml Pen 40mg/0.4ml | k | | | | | | |
| | Prefilled Syringe | - | Maintenance Dose: | | | | | + |
| | , , | | O Adolescents 12 years and older 66 lbs to <132 lbs: Inject40mg every other | | | | | |
| | | | week O Adolescents 12 years and older >132 lbs: Inject 40mg onday 29 then inject | | | | | |
| | | | | | | | | |
| O Humira | Juvenile Idiopathic Arthritis + Pediatric Uveitis | | 40mg every week | niact 10mg SC ayang | other week | | 2 | + |
| Julillia | 10mg/0.1ml Prefilled Syringe | | O 22 lbs to <33 lbs: Inject 10mg SC every other week O 33 lbs to <66 lbs: Inject 20mg SC every other week | | | | | |
| | O 20mg/0.2ml Prefilled Syringe | | other week | | | | | |
| | 40mg/0.4ml Pen | | ○ ≥66 lbs: Inject 40mg SC every | | | | | |
| | 40mg/0.4ml Prefilled Syringe | | | <u> </u> | | | | _ |
| | <110lb 75mg Syringe | | Adolescents 6 years old and up <110lb: Induction Dose: One 75mg injection under the skin at week 0, 1, 2, 3, 4. Maintenance Dose: One 75mg injection under the skin every 4 weeks | | | | | |
| Cosentyx | | | | | | | | |
| 1 | >110lb | | | ose: One 150mg inject | | • | | |
| | 150mg Prefilled Syringe 150mg Sensor Ready Pen | | 1, 2, 3, 4. | | | | | |
| | | | Maintenace Dose: O | ne 150mg injection ur | nder the skin ever | y 4 weeks | | |
| | I . | | | | | | | |
| Prescribe | r Signature (I authorize pharmacy to act as my designee for initiating | ng and coordinat | ting insurance prior authorizations, r | nursing services and patient assi | stance programs) | | | |
| Prescribe | | ng and coordinat | ting insurance prior authorizations, r | nursing services and patient assi | stance programs) Date: | | | |

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