CountyMarket Health Mart PHARMACY SPECIALTY CARE

PEDIATRIC HUMIRA® ENROLLMENT FORM

Phone: **888-450-4570** • Fax: **855-838-5857**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

❶ PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

❸ STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____
Other: _____
TB Test: ❑ Positive ❑ Negative Date: _____
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ 5-ASA	
❑ Biologics	
❑ Corticosteroids	
❑ Immunosuppressants	
❑ Methotrexate	
❑ NSAIDS	
❑ Surgery	
❑ Topical/Oral Antibiotics	
❑ UVA ❑ UVB	
❑ Others	

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

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

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

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

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ HUMIRA®	**Hidradenitis Suppurativa** ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ 80mg/0.8ml Pen ❑ 80mg/0.8ml 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 ❑ **Adolescents 12 years and older >132 lbs:** Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15, then 40mg on day 29 ❑ **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 ❑ **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 every week		
❑ 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 ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ **22 lbs to <33 lbs:** Inject 10mg SC every other week ❑ **33 lbs to <66 lbs:** Inject 20mg SC every other week ❑ **>= 33 lbs:** Inject 40mg SC every other week	2	
❑ HUMIRA®	**Pediatric Crohn's Disease** ❑ 20mg/0.2ml Prefilled Syringe ❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml (pack of 2) ❑ Pediatric Crohn's Starter Pack: 80mg/0.8ml (pack of 3)	❑ **Induction Dose:** ❑ **37 lbs to <88 lbs:** Inject one 80mg pen SC on day 1, then one 40mg pen SC on day 15 ❑ **>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 ❑ **Maintenance Dose:** ❑ **37 lbs to <88 lbs:** Inject 20mg SC every other week ❑ **>88 lbs:** Inject 40mg SC every week *All strengths and dosages listed are Humira® Citrate Free*		
❑ _____	_____	_____		

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: _____ 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.