
PRIOR
AUTHORIZATION
TRAINING
Biologics

Course Outline

1. Biologic Lists
2. Enrollment forms
3. Prior Authorization Avenues
4. Appeals
5. Patient Assistance

Bioligic List- Dermatology

1. Adbry
2. Botox
3. Cibinqo
4. Cimzia
5. Cosentyx
6. Dupixent
7. Enbrel
8. Erivedge
9. Humira
10. Ilumya
11. Otezla
12. Rinvoq
13. Skyrizi
14. Stelara
15. Taltz
16. Tremfya
17. Xolair
18. Xeljanz

Biologic indications-Dermatology

Hyperhidrosis

Botox

Psoriasis

Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Otezla, Taltz, Tremfya, Remicade, Skyrizi, Stelara

Psoriatic Arthritis

Cimzia, Cosentyx, Enbrel, Humira, Otezla, Taltz, Tremfya, Remicade, Stelara, Xeljanz

Hidradenitis Suppurativa

Humira

Chronic Idiopathic Urticaria

Xolair

Atopic Dermatitis

Dupixent, Adbry, Cibinqo, Rinvoq

Basal Cell Carcinoma

Erivedge

Biologic/Infusion List- Gastroenterology

- **Humira/Stelara – Crohn's, Ulcerative Colitis**
- **Entyvio – Crohn's, Ulcerative Colitis**
- **Faraheme – Iron deficiency anemia**
- **Remicade – Crohn's, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis**

Biologic List

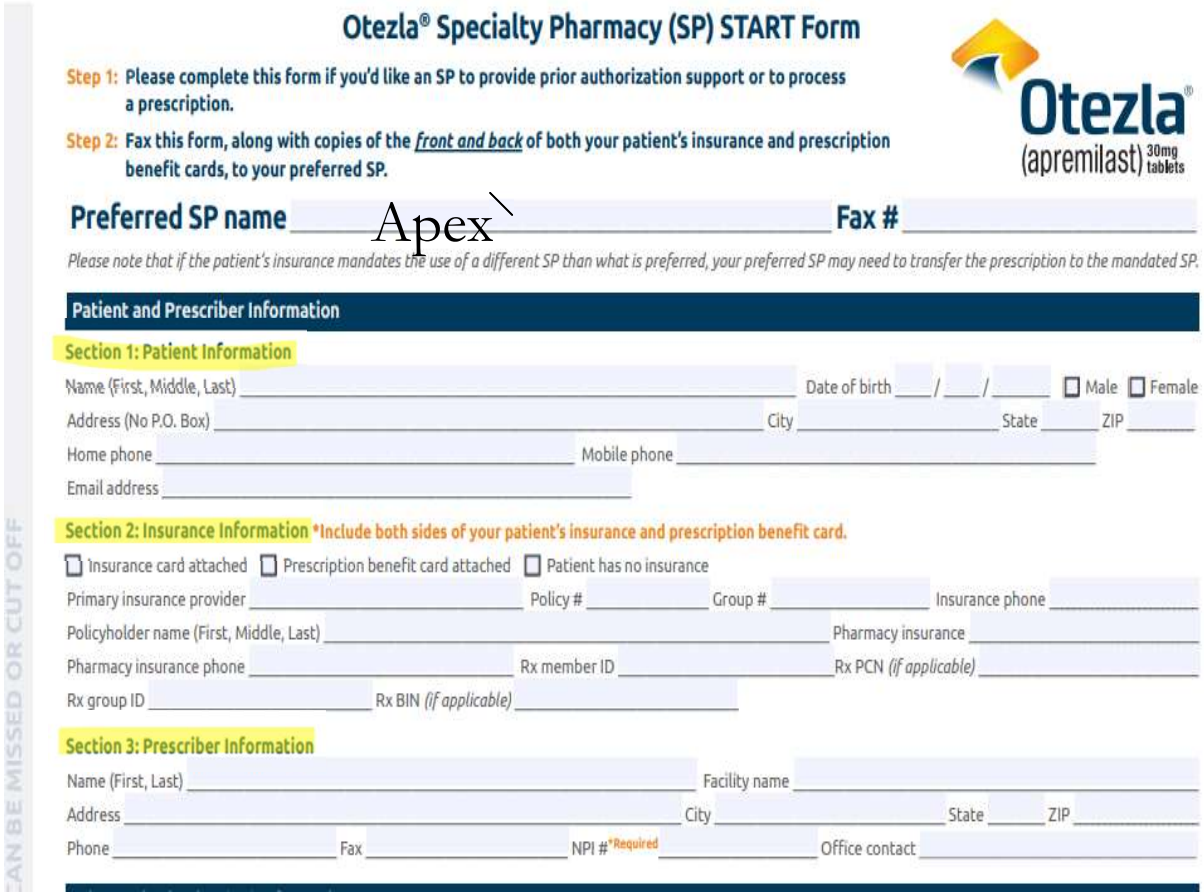
Biologic Name	Drug Company	Patient assistance
1. Adbry	Adbry Complete	LeoPharma
2. Botox	Botox/Allergan	Abbvie
3. Cibinqo	Pfizer patient access	Pfizer
4. Cimzia	Cimplicity	ucbCares
5. Cosentyx	Cosentyx Connect	Novartis
6. Dupixent	Dupixent Myway	Dupixent PAP
7. Enbrel	Enbrel	Amgen
8. Erivedge	Genentech	Foundation Assistance
9. Humira	Humira Complete	Abbvie
10.Ilumya	Ilumya Support	Ilumya PAP
11.Otezla	Otezla Support Plus	Amgen
12.Rinvoq	Rinvoq complete	Abbvie
13.Skyrizi	Skyrizi complete	Abbvie
14.Stelara	Janssen Carepath	Johnson and Johnson
15.Taltz	Taltz Together	Lily Cares
16.Tremfya	Janssen Carepath	Johnson and Johnson
17.Xolair	Genentech	Novartis
18.Xeljanz	Xelsource	Pfizer
GI	**Drug Company**	**Patient assistance**
Humira	Humira Complete	Abbvie
Entyvio	Entyvio Connect	
Faraheme	Faraheme	AMAG Pharmaceuticals
Remicade	Janssen Carepath	Johnson and Johnson
Renflexis	Merck	

Enrollment forms

- Unique to each medication
- Initiates drug company patient account
  - Helps with copay cards and patient assistance

Starts medication when available for commercially insured

- Link/bridge/quick start



Otezla® Specialty Pharmacy (SP) START Form

Otezla (apremilast) 30mg tablets

Step 1: Please complete this form if you'd like an SP to provide prior authorization support or to process a prescription.

Step 2: Fax this form, along with copies of the *front and back* of both your patient's insurance and prescription benefit cards, to your preferred SP.

Preferred SP name Apex **Fax #**

Please note that if the patient's insurance mandates the use of a different SP than what is preferred, your preferred SP may need to transfer the prescription to the mandated SP.

Patient and Prescriber Information

Section 1: Patient Information

Name (First, Middle, Last) Date of birth ___/___/_____ ☐ Male ☐ Female

Address (No P.O. Box) City State ZIP

Home phone Mobile phone

Email address

Section 2: Insurance Information *Include both sides of your patient's insurance and prescription benefit card.

☐ Insurance card attached ☐ Prescription benefit card attached ☐ Patient has no insurance

Primary insurance provider Policy # Group # Insurance phone

Policyholder name (First, Middle, Last) Pharmacy insurance

Pharmacy insurance phone Rx member ID Rx PCN *(if applicable)*

Rx group ID Rx BIN *(if applicable)*

Section 3: Prescriber Information

Name (First, Last) Facility name

Address City State ZIP

Phone Fax NPI #*Required Office contact

CAN BE MISSED OR CUT OFF

Otezla 2

UPDATE

- Patient signature no longer required

- Complete provider info section

Prior Authorization (PA) Information

☐ *I do not require PA support (please skip this section)* ☐ I would like PA support *(please complete required clinical information in this section)*

CLINICAL INFORMATION Primary diagnosis/ICD-10-CM Code:

☐ L40.0 (Psoriasis vulgaris) %BSA Affected _____
☐ L40.51 (Distal interphalangeal psoriatic arthropathy)
☐ L40.52 (Psoriatic arthritis mutilans)
☐ L40.53 (Psoriatic spondylitis)
☐ L40.59 (Other psoriatic arthropathy)
☐ L40.8 (Other psoriasis) %BSA Affected _____
☐ L40.9 (Psoriasis, unspecified) %BSA Affected _____
☐ M35.2 (Behçet's Disease)

AFFECTED AREA(S) (For PsO ONLY): ☐ Hands ☐ Arms ☐ Nails ☐ Trunk ☐ Feet ☐ Legs ☐ Scalp ☐ Groin ☐ Other_____

PREVIOUS/CURRENT TREATMENT:

Medication	Duration/Reason for discontinuation	Medication	Duration/Reason for discontinuation
☐ Methotrexate		☐ Orals _____	
☐ Cyclosporine		☐ Topicals _____	
☐ Sulfasalazine		☐ Biologics _____	
☐ Acitretin		☐ Other _____	
☐ PUVA or UV			
☐ Colchicine			

ADDITIONAL MEDICAL JUSTIFICATION:_____
*Include any clinical notes helpful in establishing diagnosis.

Prescription Information for Otezla® (apremilast) FOR ORAL USE

Starting with in-office sample

Date titration sample was provided to patient: _____ / _____ / _____ In-office 2-WEEK TITRATION SAMPLE x14 days, 27 tablets, 0 refills
*Note the patient's start date if you directly provided the in-office sample to your patient.

Starting with the Specialty Pharmacy

Titration Starter Pack Rx is only for patients who did not receive a sample during their office visit. The SP will notify the patient via telephone prior to each shipment

☐ Titration Dose: 4-WEEK STARTER PACK x28 days, 55 tablets, 0 refills

Maintenance Dose: 30 mg of Otezla®
☐ Twice daily ☐ Once-daily renal dose 30 mg (For patients with severe renal impairment)
☐ x30 days ☐ x90 days Refills: ☐ 11 or ☐ Other (enter #) _____
Special instructions_____

*Prescriber signature (dispense as written) _____ Date ___ / ___ / ____

*Supervising physician signature and date (where required) _____ Date ___ / ___ / ____

All items marked with an * are required.

Scan Me

Encourage patients to enroll in the combined Co-Pay & Bridge Program by scanning the QR code, visiting otezla.com, or calling 1-844-4OTEZLA (1-844-468-3952).

Please see the back page for Indications and Important Safety Information.
Please click here for Full Prescribing Information.

AMGEN®

2

- *UPDATED*
- Prescription section needs to be marked completed (no bridge section)
- Verify provider signature has a date prior to faxing
- **Patient needs to sign up for bridge/copay card**

All items marked with an * are required.

Scan Me

Encourage patients to enroll in the combined Co-Pay & Bridge Program by scanning the QR code, visiting otezla.com, or calling 1-844-4OTEZLA (1-844-468-3952).

Please see the back page for Indications and Important Safety Information.

Please click here for Full Prescribing Information.

AMGEN®

Enroll in the $0 Co-Pay* Program

Getting an Otezla $0 Co-Pay Card

Did you know the majority of people pay $0 a month for Otezla?

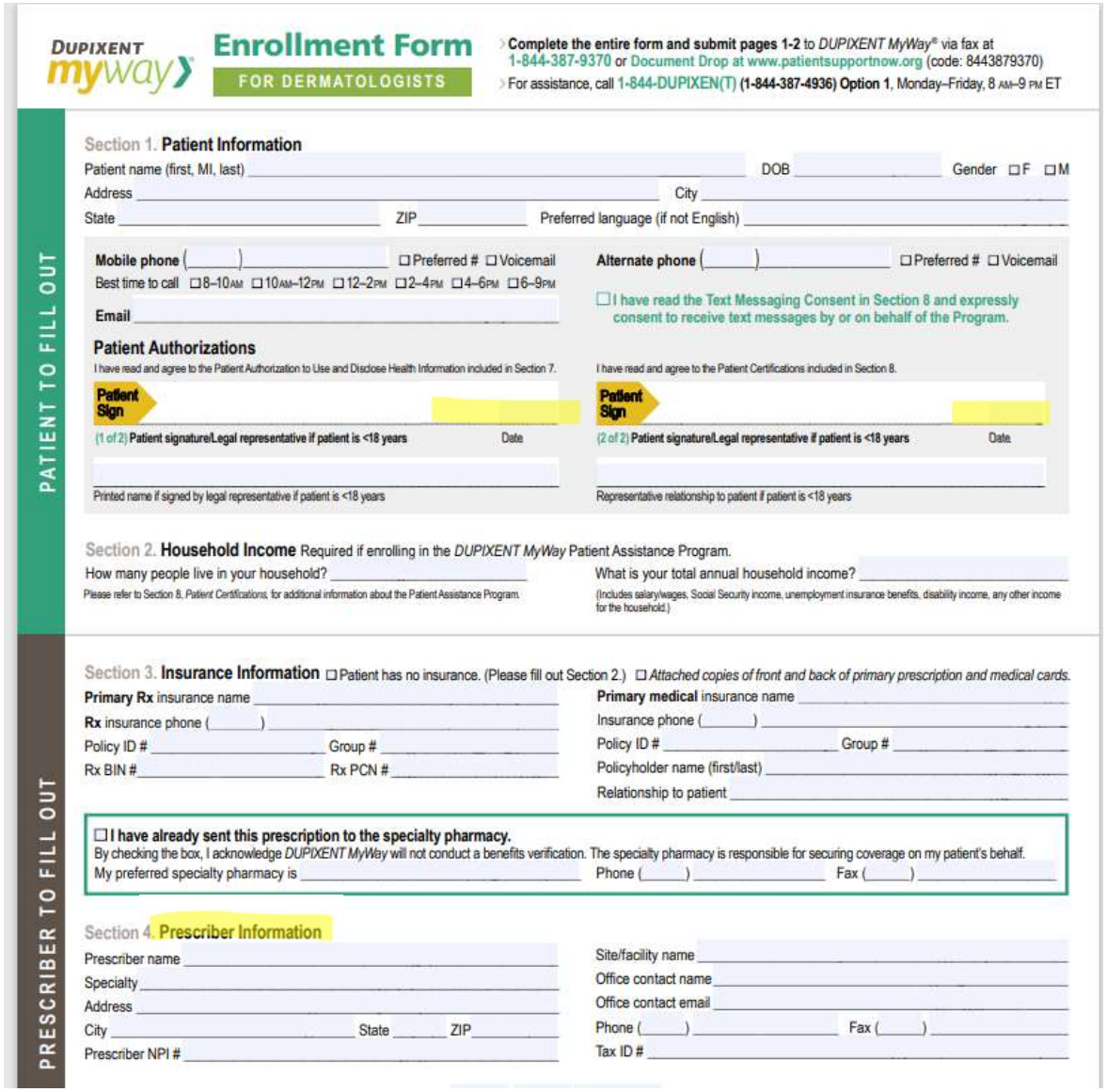
Just **fill out and submit the form** below—if you're eligible, you'll be automatically enrolled and **your new $0 Co-Pay Card** will be sent to you ready to use.

Prefer to do things over the phone? You can also call **1-844-4OTEZLA** (**1-844-468-3952**) and speak to a SupportPlus™ team member to enroll (available 8 AM – 8 PM ET, Monday – Friday).

UPDATE

Commercial patients;

- 1. Use QR Code
- Takes you directly to copay card section of website
- 2. Otezlasupport.com
  - Savings and support
  - $0 dollar copay card offer
  - Sign up



DUPIXENT myway

Enrollment Form

FOR DERMATOLOGISTS

› **Complete the entire form and submit pages 1-2** to *DUPIXENT MyWay®* via fax at 1-844-387-9370 or Document Drop at www.patientsupportnow.org (code: 8443879370)

› For assistance, call 1-844-DUPIXEN(T) **(1-844-387-4936) Option 1**, Monday–Friday, 8 AM–9 PM ET

PATIENT TO FILL OUT

Section 1. Patient Information

Patient name (first, MI, last) _____ DOB _____ Gender ☐F ☐M

Address _____ City _____

State _____ ZIP _____ Preferred language (if not English) _____

Mobile phone (_____) _____ ☐Preferred # ☐Voicemail

Best time to call ☐8–10AM ☐10AM–12PM ☐12–2PM ☐2–4PM ☐4–6PM ☐6–9PM

Email _____

Alternate phone (_____) _____ ☐Preferred # ☐Voicemail

☐I have read the Text Messaging Consent in Section 8 and expressly consent to receive text messages by or on behalf of the Program.

Patient Authorizations

I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 7.

Patient Sign _____

(1 of 2) **Patient signature/Legal representative if patient is <18 years** Date

Printed name if signed by legal representative if patient is <18 years

I have read and agree to the Patient Certifications included in Section 8.

Patient Sign _____

(2 of 2) **Patient signature/Legal representative if patient is <18 years** Date

Representative relationship to patient if patient is <18 years

Section 2. Household Income Required if enrolling in the *DUPIXENT MyWay* Patient Assistance Program.

How many people live in your household? _____

Please refer to Section 8, *Patient Certifications*, for additional information about the Patient Assistance Program.

What is your total annual household income? _____

(Includes salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.)

PRESCRIBER TO FILL OUT

Section 3. Insurance Information ☐Patient has no insurance. (Please fill out Section 2.) ☐*Attached copies of front and back of primary prescription and medical cards.*

Primary Rx insurance name _____

Rx insurance phone (_____) _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Primary medical insurance name _____

Insurance phone (_____) _____

Policy ID # _____ Group # _____

Policyholder name (first/last) _____

Relationship to patient _____

☐**I have already sent this prescription to the specialty pharmacy.**

By checking the box, I acknowledge *DUPIXENT MyWay* will not conduct a benefits verification. The specialty pharmacy is responsible for securing coverage on my patient's behalf.

My preferred specialty pharmacy is _____ Phone (_____) _____ Fax (_____) _____

Section 4. Prescriber Information

Prescriber name _____

Specialty _____

Address _____

City _____ State _____ ZIP _____

Prescriber NPI # _____

Site/facility name _____

Office contact name _____

Office contact email _____

Phone (_____) _____ Fax (_____) _____

Tax ID # _____

1

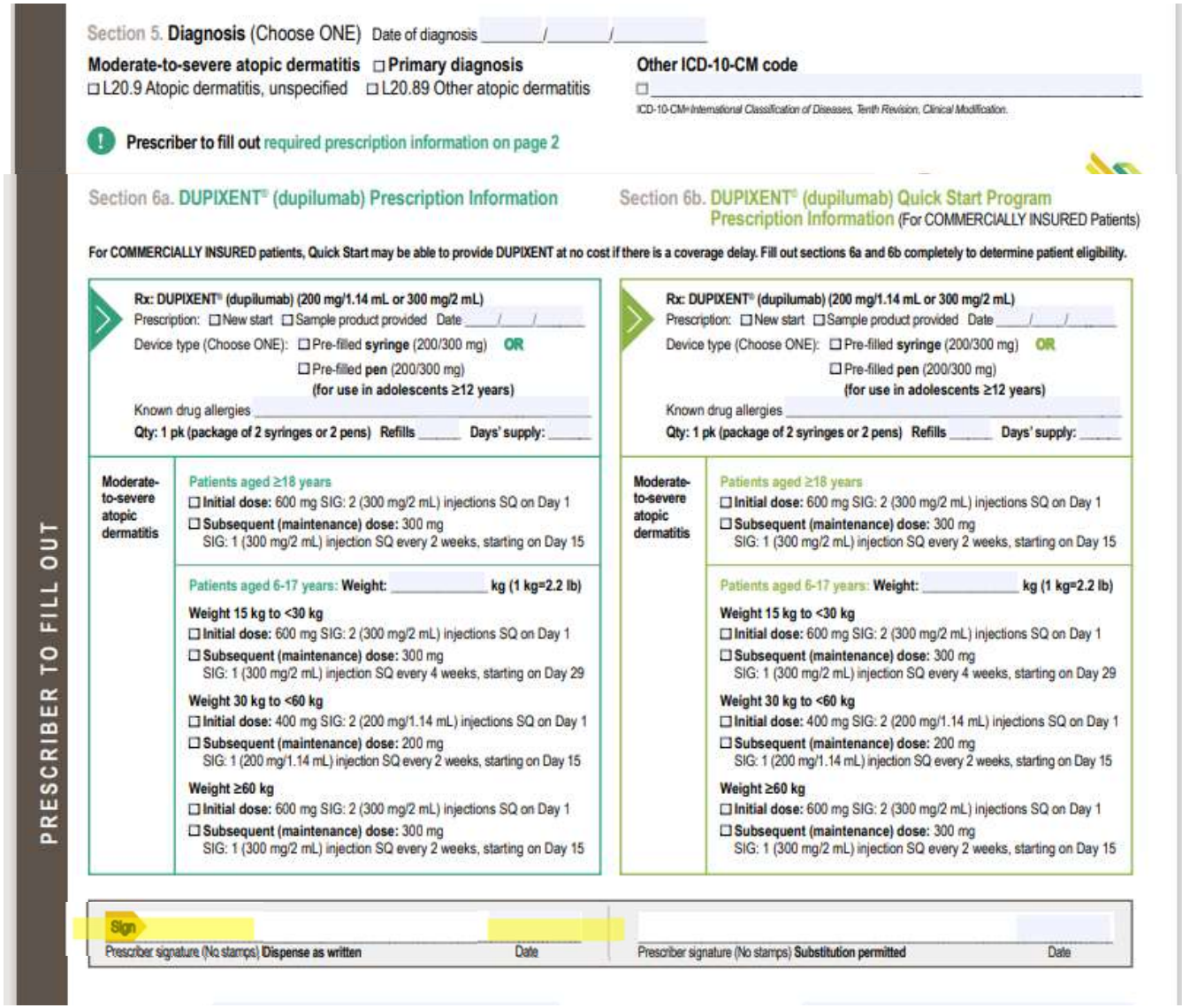
Dupixent
2022 new form

.

Patient must sign BOTH

Boxes AND date

-



PRESCRIBER TO FILL OUT

Section 5. **Diagnosis** (Choose ONE) Date of diagnosis ____/____/____

Moderate-to-severe atopic dermatitis ☐ **Primary diagnosis**
☐ L20.9 Atopic dermatitis, unspecified ☐ L20.89 Other atopic dermatitis

Other ICD-10-CM code
☐ _____
ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

Prescriber to fill out required prescription information on page 2

Section 6a. DUPIXENT® (dupilumab) Prescription Information

Section 6b. DUPIXENT® (dupilumab) Quick Start Program Prescription Information (For COMMERCIALLY INSURED Patients)

For COMMERCIALLY INSURED patients, Quick Start may be able to provide DUPIXENT at no cost if there is a coverage delay. Fill out sections 6a and 6b completely to determine patient eligibility.

Rx: DUPIXENT® (dupilumab) (200 mg/1.14 mL or 300 mg/2 mL)
Prescription: ☐ New start ☐ Sample product provided Date ____/____/____
Device type (Choose ONE): ☐ Pre-filled **syringe** (200/300 mg) **OR**
☐ Pre-filled **pen** (200/300 mg)
(for use in adolescents ≥12 years)
Known drug allergies _____
Qty: 1 pk (package of 2 syringes or 2 pens) Refills _____ **Days' supply:** _____

Moderate-to-severe atopic dermatitis

Patients aged ≥18 years
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15

Patients aged 6-17 years: **Weight:** _____ **kg (1 kg=2.2 lb)**

Weight 15 kg to <30 kg
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 4 weeks, starting on Day 29

Weight 30 kg to <60 kg
☐ **Initial dose:** 400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 200 mg
SIG: 1 (200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15

Weight ≥60 kg
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15

Rx: DUPIXENT® (dupilumab) (200 mg/1.14 mL or 300 mg/2 mL)
Prescription: ☐ New start ☐ Sample product provided Date ____/____/____
Device type (Choose ONE): ☐ Pre-filled **syringe** (200/300 mg) **OR**
☐ Pre-filled **pen** (200/300 mg)
(for use in adolescents ≥12 years)
Known drug allergies _____
Qty: 1 pk (package of 2 syringes or 2 pens) Refills _____ **Days' supply:** _____

Moderate-to-severe atopic dermatitis

Patients aged ≥18 years
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15

Patients aged 6-17 years: **Weight:** _____ **kg (1 kg=2.2 lb)**

Weight 15 kg to <30 kg
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 4 weeks, starting on Day 29

Weight 30 kg to <60 kg
☐ **Initial dose:** 400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 200 mg
SIG: 1 (200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15

Weight ≥60 kg
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15

Sign
Prescriber signature (No stamps) **Dispense as written** Date

Prescriber signature (No stamps) **Substitution permitted** Date

Dupixent RX

Diagnosis section-pg1

Page 2

Both prescriptions are next to each other

- Select device type
- Dose
- Provider only needs to sign ONCE now
  - DON'T FOREGET DATES ON SIG

Eczema Area and Severity Index (EASI) case report form - age≥8 years

Area of Involvement: Each body region has potentially 100% involvement. Score **0 to 6** based on the following table:

% involvement	0	1-9%	10 - 29%	30 - 49%	50 - 69%	70 - 89%	90 - 100%
Region score	0	1	2	3	4	5	6

Severity of Signs: Grade the severity of each sign on a scale of **0 to 3**:

0	None
1	Mild
2	Moderate
3	Severe

- ✓ Take an average of the severity across the involved area.
- ✓ Half points (1.5 and 2.5) may be used. 0.5 is not permitted – if a sign is present it should be at least mild (1)

Scoring table:

Body region	Erythema (0-3)	Edema/ Papulation (0-3)	Excoriation (0-3)	Lichenification (0-3)	Region score (0-6)	Multiplier	Score per body region
Head/neck	(+	+	+	)	X	X 0.1	
Trunk	(+	+	+	)	X	X 0.3	
Upper extremities	(+	+	+	)	X	X 0.2	
Lower extremities	(+	+	+	)	X	X 0.4	
The final EASI score is the sum of the 4 region scores:							_____ (0-72)

Dupixent-(EASI)

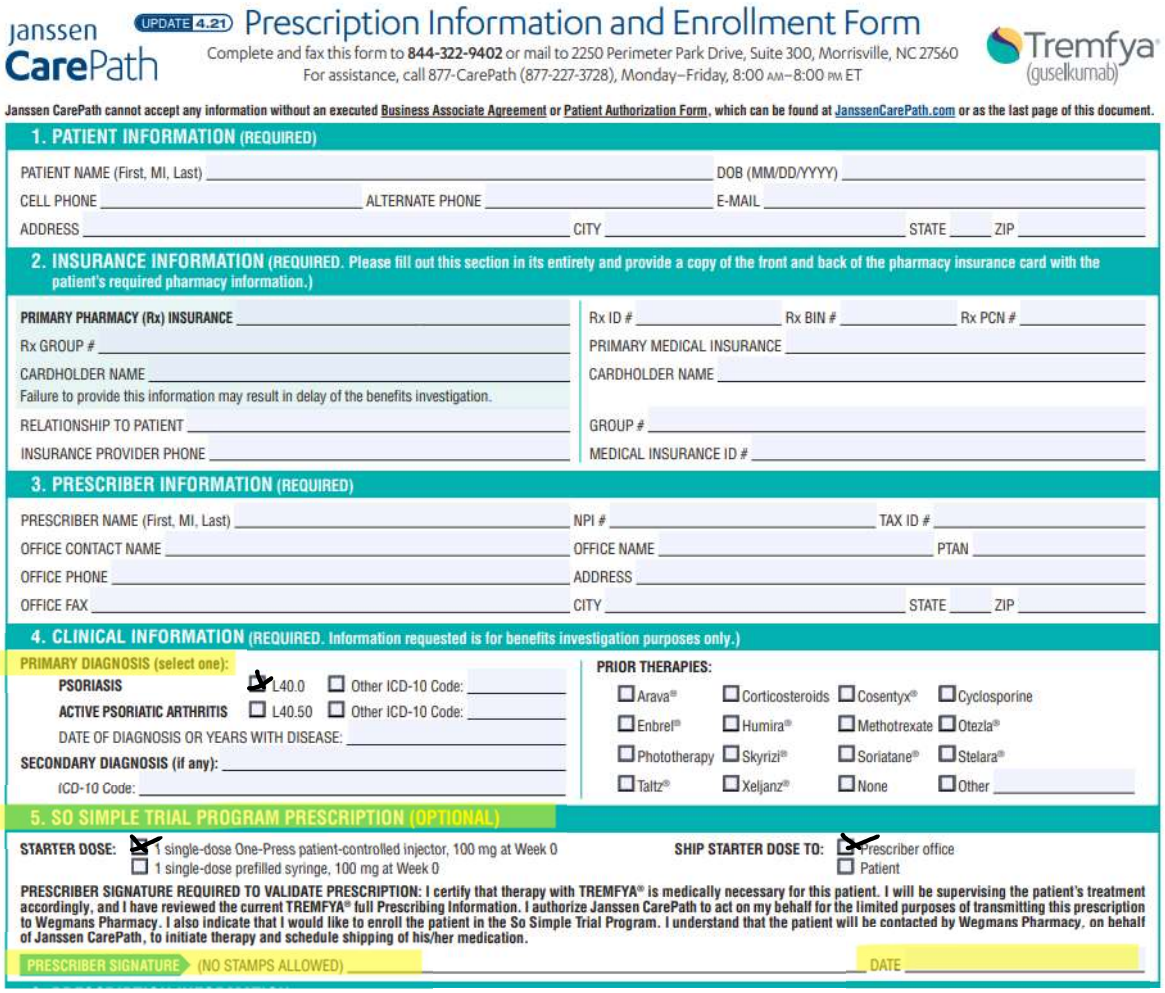
All Medicaid INS requests EASI score for Dupixent

Renewals

-INS requires 75% improvement from baseline

Fax to Apex with enrollment form

(providers can document in chart notes as well)



Janssen CarePath UPDATE 4.21 Prescription Information and Enrollment Form

Complete and fax this form to **844-322-9402** or mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

Tremfya (guselkumab)

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last page of this document.

1. PATIENT INFORMATION (REQUIRED)

PATIENT NAME (First, MI, Last) _____ DOB (MM/DD/YYYY) _____
CELL PHONE _____ ALTERNATE PHONE _____ E-MAIL _____
ADDRESS _____ CITY _____ STATE ____ ZIP _____

2. INSURANCE INFORMATION (REQUIRED. Please fill out this section in its entirety and provide a copy of the front and back of the pharmacy insurance card with the patient's required pharmacy information.)

PRIMARY PHARMACY (Rx) INSURANCE _____ Rx ID # _____ Rx BIN # _____ Rx PCN # _____
Rx GROUP # _____ PRIMARY MEDICAL INSURANCE _____
CARDHOLDER NAME _____ CARDHOLDER NAME _____
Failure to provide this information may result in delay of the benefits investigation.
RELATIONSHIP TO PATIENT _____ GROUP # _____
INSURANCE PROVIDER PHONE _____ MEDICAL INSURANCE ID # _____

3. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, MI, Last) _____ NPI # _____ TAX ID # _____
OFFICE CONTACT NAME _____ OFFICE NAME _____ PTAN _____
OFFICE PHONE _____ ADDRESS _____
OFFICE FAX _____ CITY _____ STATE ____ ZIP _____

4. CLINICAL INFORMATION (REQUIRED. Information requested is for benefits investigation purposes only.)

PRIMARY DIAGNOSIS (select one):
PSORIASIS ☑ L40.0 ☐ Other ICD-10 Code: _____
ACTIVE PSORIATIC ARTHRITIS ☐ L40.50 ☐ Other ICD-10 Code: _____
DATE OF DIAGNOSIS OR YEARS WITH DISEASE: _____
SECONDARY DIAGNOSIS (if any): _____
ICD-10 Code: _____

PRIOR THERAPIES:
☐ Arava® ☐ Corticosteroids ☐ Cosentyx® ☐ Cyclosporine
☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ Otezla®
☐ Phototherapy ☐ Skyrizi® ☐ Soriatane® ☐ Stelara®
☐ Taltz® ☐ Xeljanz® ☐ None ☐ Other _____

5. SO SIMPLE TRIAL PROGRAM PRESCRIPTION (OPTIONAL)

STARTER DOSE: ☑ 1 single-dose One-Press patient-controlled injector, 100 mg at Week 0
☐ 1 single-dose prefilled syringe, 100 mg at Week 0

SHIP STARTER DOSE TO: ☑ Prescriber office ☐ Patient

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to Wegmans Pharmacy. I also indicate that I would like to enroll the patient in the So Simple Trial Program. I understand that the patient will be contacted by Wegmans Pharmacy, on behalf of Janssen CarePath, to initiate therapy and schedule shipping of his/her medication.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

Tremfya

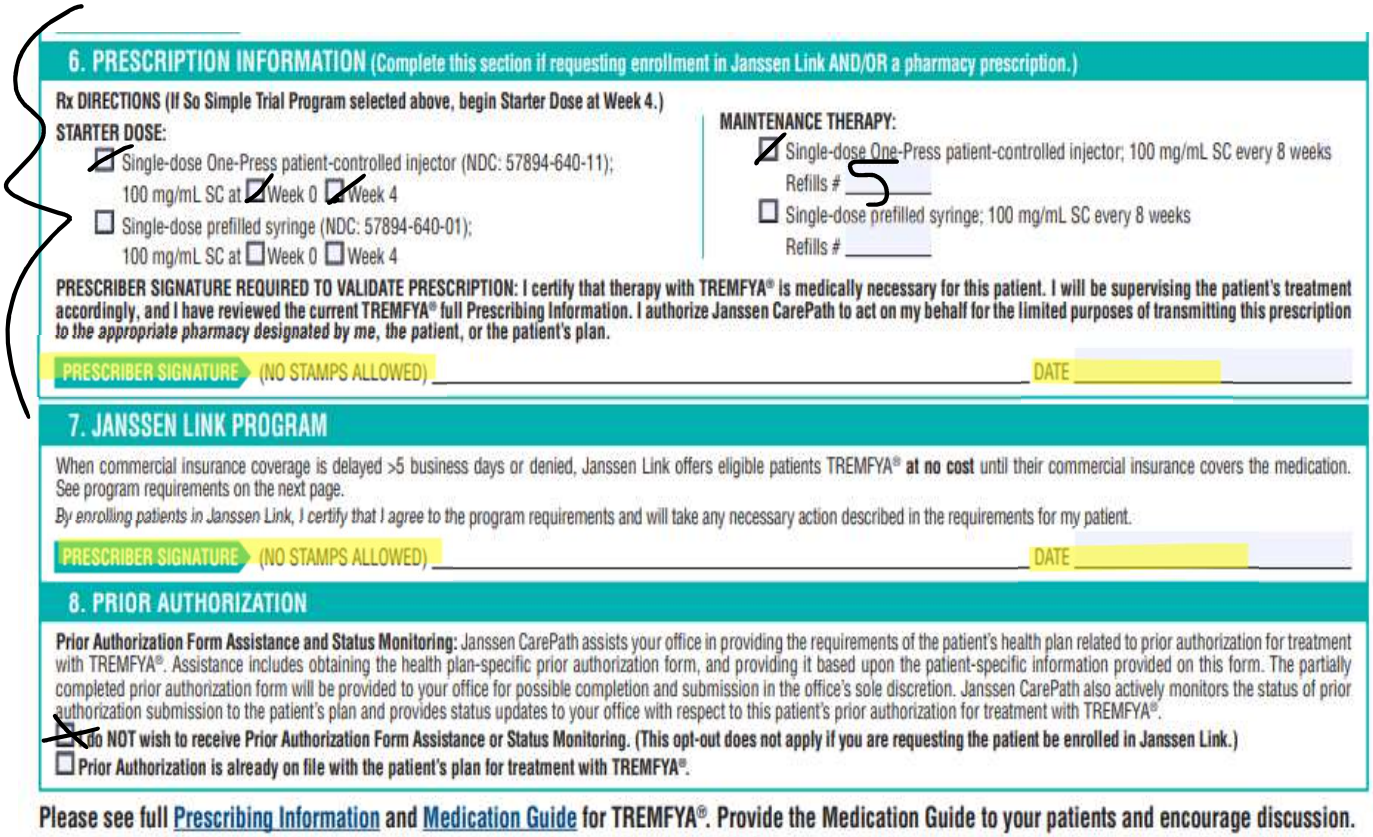
Complete diagnosis section

.

So Simple dose

- This sends to ALL insurance types

- First dose should go to prescriber office



6. PRESCRIPTION INFORMATION (Complete this section if requesting enrollment in Janssen Link AND/OR a pharmacy prescription.)

Rx DIRECTIONS (If So Simple Trial Program selected above, begin Starter Dose at Week 4.)

STARTER DOSE:

- ☑ Single-dose One-Press patient-controlled injector (NDC: 57894-640-11); 100 mg/mL SC at ☑ Week 0 ☑ Week 4
- ☐ Single-dose prefilled syringe (NDC: 57894-640-01); 100 mg/mL SC at ☐ Week 0 ☐ Week 4

MAINTENANCE THERAPY:

- ☑ Single-dose One-Press patient-controlled injector; 100 mg/mL SC every 8 weeks
  Refills # 5
- ☐ Single-dose prefilled syringe; 100 mg/mL SC every 8 weeks
  Refills # _____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription *to the appropriate pharmacy designated by me, the patient, or the patient's plan.*

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

7. JANSSEN LINK PROGRAM

When commercial insurance coverage is delayed >5 business days or denied, Janssen Link offers eligible patients TREMFYA® **at no cost** until their commercial insurance covers the medication. See program requirements on the next page.

By enrolling patients in Janssen Link, I certify that I agree to the program requirements and will take any necessary action described in the requirements for my patient.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

8. PRIOR AUTHORIZATION

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with TREMFYA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with TREMFYA®.

- ☐ **I do NOT wish to receive Prior Authorization Form Assistance or Status Monitoring. (This opt-out does not apply if you are requesting the patient be enrolled in Janssen Link.)**
- ☐ **Prior Authorization is already on file with the patient's plan for treatment with TREMFYA®.**

Please see full Prescribing Information and Medication Guide for TREMFYA®. Provide the Medication Guide to your patients and encourage discussion.

Link RX

Prescription section

-Used for link

(free program while waiting for INS or if denied)

- Provider sig and date needed

Link Program

-Commercially insured ONLY

-Provider sig and date needed

taltz together™
(ixekizumab) injection

PATIENT ENROLLMENT SECTION
Taltz® (ixekizumab) Dermatology

OFFICE: Please fax to 1-844-344-8108

Patient

Patient Name (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

Address _____ **City** _____ **State** _____ **Zip** _____

US or Puerto Rico Resident ☐ Yes ☐ No **Gender** ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone* _____ **Email** _____

*By providing my telephone number and signing this form, I agree to receive automated marketing calls and texts from and on behalf of Eli Lilly and Company. I understand that I am not required to provide my number as a condition of purchase. Message and data rates may apply.

Signature of Patient _____ **Date Signed (MM/DD/YYYY)** _____

Not signing this form will result in an incomplete submission and a delay in requested services

Must select one of the following: ☐ **No Insurance Coverage** ☐ **Copy of Policyholder's Insurance Card (Front and Back) Is Attached** ☐ **Provide Information Below**

Primary Prescription Insurance Company _____

Insurance Company Phone # _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

RX BIN _____ **PCN** _____

Please select which options you would like to enroll in by checking the corresponding checkboxes below.

☒ I would like a **Taltz® Savings Card** and agree to the Savings Card Terms and Conditions on page 6

SAVINGS CARD ELIGIBILITY (must confirm the below statements in order to be eligible)

☐ I confirm that I am a resident of the United States or Puerto Rico who is 18 years of age or older

☐ I confirm that I am NOT enrolled in a government-funded prescription program. Examples include Medicaid, Medicare, Medicare Part D, and others

☐ I would like **Taltz Together™ Ongoing Support** and agree to the Optional Taltz Together™ Ongoing Support Enrollment Consent on page 6

☐ I would like **Injection Training Support** and agree to the Optional Taltz Together™ Ongoing Support Enrollment Consent on page 6

☐ I would like **Sharps Disposal Support**

I have read and agree to the Patient HIPAA Authorization. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient _____ **Date Signed (MM/DD/YYYY)** _____

Printed Name of Patient _____ **Date of Birth (MM/DD/YYYY)** _____

Not signing this form will result in an incomplete submission and a delay in requested services

Lilly

2

Taltz

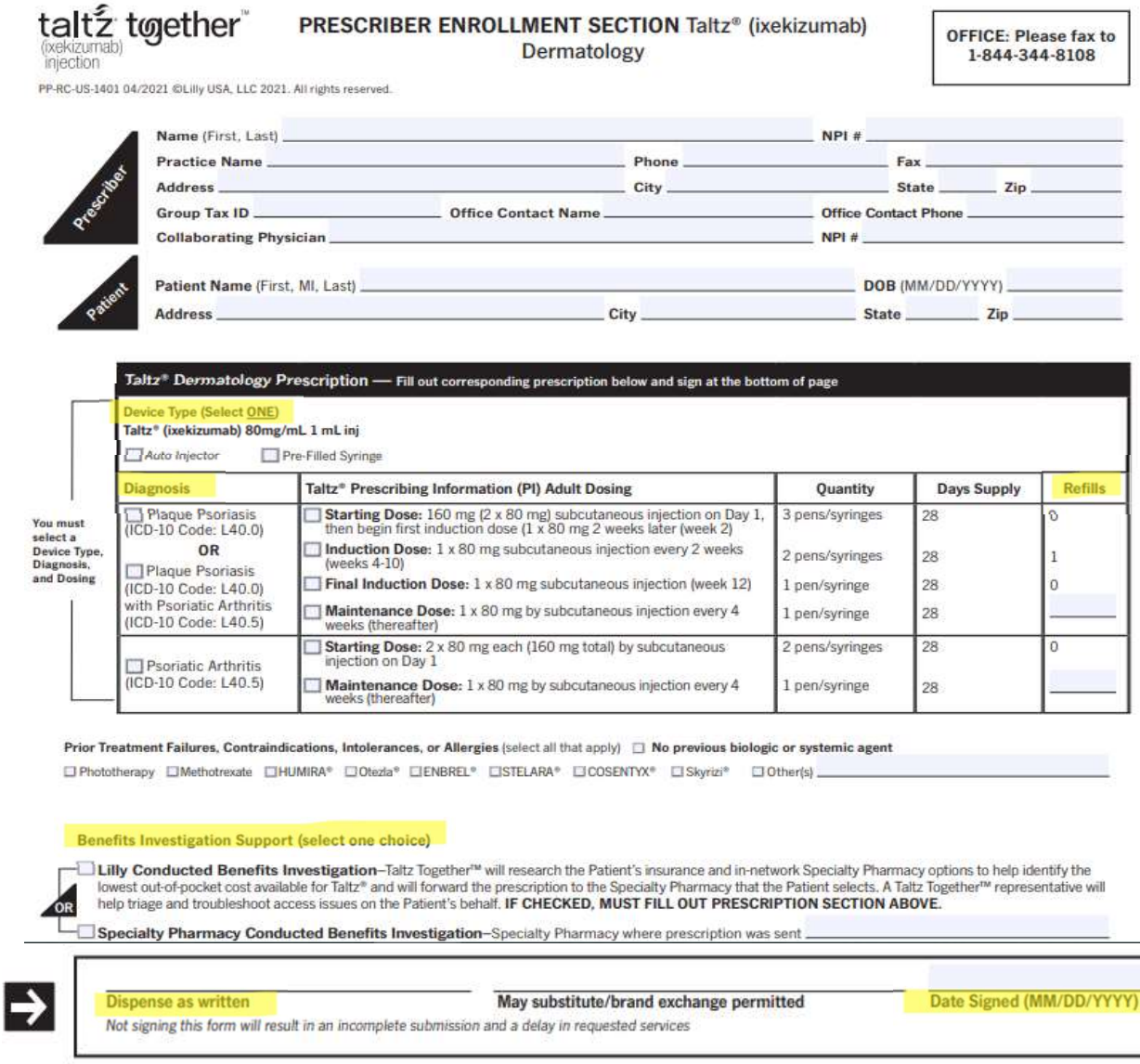
New enrollment updated 8/2021

7 pages

Two patient sig needed

-page 1 and 3

If patient misses HIPAA-Can call to complete



taltz together™ (ixekizumab) injection

PRESCRIBER ENROLLMENT SECTION Taltz® (ixekizumab)
Dermatology

OFFICE: Please fax to 1-844-344-8108

Prescriber

Name (First, Last) _____ NPI # _____
Practice Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____
Group Tax ID _____ Office Contact Name _____ Office Contact Phone _____
Collaborating Physician _____ NPI # _____

Patient

Patient Name (First, MI, Last) _____ DOB (MM/DD/YYYY) _____
Address _____ City _____ State _____ Zip _____

Taltz® Dermatology Prescription — Fill out corresponding prescription below and sign at the bottom of page

Device Type (Select ONE)
Taltz® (ixekizumab) 80mg/mL 1 mL inj
☐ Auto Injector ☐ Pre-Filled Syringe

You must select a Device Type, Diagnosis, and Dosing

Diagnosis	Taltz® Prescribing Information (PI) Adult Dosing	Quantity	Days Supply	Refills
☐ Plaque Psoriasis (ICD-10 Code: L40.0) OR ☐ Plaque Psoriasis (ICD-10 Code: L40.0) with Psoriatic Arthritis (ICD-10 Code: L40.5)	☐ **Starting Dose:** 160 mg (2 x 80 mg) subcutaneous injection on Day 1, then begin first induction dose (1 x 80 mg 2 weeks later (week 2)	3 pens/syringes	28	0
	☐ **Induction Dose:** 1 x 80 mg subcutaneous injection every 2 weeks (weeks 4-10)	2 pens/syringes	28	1
	☐ **Final Induction Dose:** 1 x 80 mg subcutaneous injection (week 12)	1 pen/syringe	28	0
	☐ **Maintenance Dose:** 1 x 80 mg by subcutaneous injection every 4 weeks (thereafter)	1 pen/syringe	28	_____
☐ Psoriatic Arthritis (ICD-10 Code: L40.5)	☐ **Starting Dose:** 2 x 80 mg each (160 mg total) by subcutaneous injection on Day 1	2 pens/syringes	28	0
	☐ **Maintenance Dose:** 1 x 80 mg by subcutaneous injection every 4 weeks (thereafter)	1 pen/syringe	28	_____

Prior Treatment Failures, Contraindications, Intolerances, or Allergies (select all that apply) ☐ **No previous biologic or systemic agent**

☐ Phototherapy ☐ Methotrexate ☐ HUMIRA® ☐ Otezla® ☐ ENBREL® ☐ STELARA® ☐ COSENTYX® ☐ Skyrizi® ☐ Other(s) _____

Benefits Investigation Support (select one choice)

☐ **Lilly Conducted Benefits Investigation**–Taltz Together™ will research the Patient's insurance and in-network Specialty Pharmacy options to help identify the lowest out-of-pocket cost available for Taltz® and will forward the prescription to the Specialty Pharmacy that the Patient selects. A Taltz Together™ representative will help triage and troubleshoot access issues on the Patient's behalf. **IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION ABOVE.**

OR

☐ **Specialty Pharmacy Conducted Benefits Investigation**–Specialty Pharmacy where prescription was sent _____

Dispense as written _____ May substitute/brand exchange permitted _____ Date Signed (MM/DD/YYYY) _____

Not signing this form will result in an incomplete submission and a delay in requested services

2

Taltz Rx

Device type needs marked

Diagnosis marked

-Select prescription per diagnosis

- add refills accordingly

(this prescription will be used for 25 dollar copay card program)

- Commercially INS only
- Benefits
  - Notate specialty : APEX

Provider Sig and date needed

Apex -Derm

- Complete for medication
- Send with chart notes/TB test
  - Notate waiting on labs

APEX SPECIALTY PHARMACY

DERMATOLOGY

Phone: 855.257.2584 || Fax: 866.680.3539

Date _____
Ship to: ☐ Patient ☐ Provider
☐ NEW START ☐ Continuation

PATIENT INFORMATION

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10)
☐ L20. ____ Atopic Dermatitis ☐ C44.____ Basal Cell Carcinoma ☐ L73.2 Hidradenitis Suppurativa
☐ L74.51 ____ Hyperhidrosis ☐ L40. ____ Plaque Psoriasis ☐ L40. ____ Psoriatic Arthritis ☐ L50.____ Urticaria

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

Tried/Failed Therapies: ☐ Cimzia ☐ Cosentyx ☐ Cyclosporine ☐ Dupixent ☐ Enbrel ☐ Humira ☐ Ilumya ☐ Methotrexate ☐ Odomzo ☐ Orencia ☐ Otezla ☐ PUVA/UVB ☐ Remicade ☐ Simponi ☐ Sivextro ☐ Skyrizi ☐ Soriatane ☐ Stelara ☐ Taltz ☐ Topicals ☐ Tremfya

BSA: _____% ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Other Areas _____
PPD/Chest X-Ray for TB? ☐ Yes ☐ No Drug Allergies: _____

PRESCRIPTION INFORMATION

☐ Cimzia	☐ 200x2 PFS ☐ 200x2 LYO	☐ Start: Inject 400mg SQ at weeks 0, 2, and 4 (qty 3 kits) ☐ Maint: Inject ____mg SQ every: ☐ 2 ☐ 4 wks (qty ____) ***Pt. weight ____ lbs***	Refill: 0 Refill:
☐ Cosentyx	☐ 150mg Sensoready PEN ☐ 150mg PFS	☐ Start: Inject 2-150mg (300mg) SQ at Weeks 0, 1, 2, 3, and 4 (qty ____) ☐ Maint: Inject 2-150mg (300mg) SQ every 4 weeks (qty 2)	Refill: 0 Refill:
☐ Dupixent	☐ 200mg PFS ☐ 300mg PFS ☐ 300mg PEN	☐ Start: Inject 2-____mg (____mg) SQ in different injection sites at Week 0 (qty 2) ☐ Maint: Inject ____mg every ____ week(s) (qty ____)	Refill: 0 Refill:
☐ Enbrel	☐ 50mg Enbrel Mini ☐ 50mg Sureclick ☐ 50mg PFS ☐ 0.8 mg/kg	☐ Inject 50mg SQ TWICE a week, 72-96 hours apart (qty 8) for 12 weeks ☐ Inject 50mg SQ ONCE a week (qty 4) ☐ Inject 0.8 mg/kg ONCE a week (qty 4) ***Pt. weight ____ lbs***	Refill:
☐ Humira Starter Kit ***Citrate free***	☐ 80mg/0.8ml (qty 1) and 40/0.4ml PEN (qty 2) ☐ 80mg/0.8ml PEN (qty 3)	☐ Inject 80mg SQ on Day 1, then 40mg SQ on Day 8, then 40mg every other week ☐ Inject 160mg SQ on Day 1 or 80mg per day on Days 1 and 2, then 80mg on Day 15, then 40mg every week	Refill: 0
☐ Humira Maintenance ***Citrate free***	☐ 40mg/0.4ml PEN ☐ 40mg/0.4ml PFS ☐ 80mg/0.8ml PEN	☐ Inject 40mg SQ every ____ week(s) (qty ____) ☐ Inject 80mg SQ every ____ week(s) (qty ____)	Refill:
☐ Ilumya	☐ 100mg/ml PFS	☐ Start: Inject 100mg SQ at week 0 and week 4, then every 12 weeks (qty 2)	Refill:
☐ Odomzo	☐ 200mg Capsule	☐ Take 1 Capsule ONCE daily on an empty stomach (qty 30)	Refill:
☐ Otezla	☐ Starter Kit ☐ 30mg Tablet	☐ Take Starter Dosing per instructions (qty 55 // 28 days) [☐ *Office provided*] ☐ Take 1 tablet by mouth twice daily (qty 60 // 30 days)	Refill: 0 Refill:
☐ Simponi	☐ 50mg SmartJect ☐ 50mg PFS	☐ Inject 50mg SQ ONCE a MONTH as directed (qty 1)	Refill:
☐ Sivextro	☐ 200mg Tablet	☐ Take 1 Tablet ONCE daily (qty 6)	Refill:
☐ Skyrizi	☐ 75mg PFS	☐ Inject 150mg SQ at week 0 and week 4, then every 12 weeks (qty 4)	Refill:
☐ Stelara	☐ 45mg PFS ☐ 90mg PFS	☐ Start: Inject ____mg SQ day 0, then on day 28 (qty 2) ☐ Maint: Inject ____mg SQ every 12 weeks (qty 1) ***Pt. weight _____lbs***	Refill: 0 Refill:
☐ Taltz	☐ 80mg Autoinjector ☐ 80mg PFS	☐ Start: Inject 160mg SQ at Week 0, then 80mg at Weeks 2, 4, 6, 8, 10, 12 (qty 8) ☐ Maint: Inject 80mg SQ every 4 weeks (qty 1)	Refill: 0 Refill:
☐ Tremfya	☐ 100mg Autoinjector ☐ 100mg PFS	☐ Start: Inject 100mg SQ at Week 0, then on day 28 (qty 2) ☐ Maint: Inject 100mg SQ every 8 weeks (qty 1)	Refill: 0 Refill:

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Apex- GI

We have not utilized this yet

Can be used for assistance to initiate PA

APEX SPECIALTY PHARMACY

GASTROENTEROLOGY

Phone: 855.257.2584 || Fax: 866.680.3539

Date _____
Ship to: ☐ Patient ☐ Provider
☐ NEW START ☐ Continuation

PATIENT INFORMATION

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office Fax:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10 // ICD-9)

☐ K50. ____ // 555.0 Crohn's Disease ☐ K51. ____ // 556.9 Ulcerative Colitis ☐ Other:

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

Immunosuppressants	☐ 5-ASA ☐ Azathioprine ☐ Budesonide ☐ Mercaptopurine ☐ Mesalamine ☐ Prednisone ☐ Sulfasalazine	
Biologics	☐ Cimzia ☐ Entyvio ☐ Humira ☐ Remicade ☐ Simponi ☐ Stelara ☐ Xeljanz ☐ Xifaxan	
PPD/Chest X-Ray for TB?	☐ Yes ☐ No	Drug Allergies (list):

PRESCRIPTION INFORMATION

☐ Cimzia	☐ Prefilled Syringe ☐ LYO Powder	☐ Initial: Inject 400mg SQ at weeks 0, 2 and 4 (qty 3 kits) ☐ Maint: Inject _____mg SC every: ☐ 2 ☐ 4 wks (qty _____)	Refill: 0 Refill:
☐ Dificid	☐ 200mg Tablet	1 Tablet Twice Daily (qty 20)	Refill: 0
☐ Humira Induction ***Citrate free***	☐ 80mg/0.8ml PEN (qty 3)	☐ Inject 160mg SQ on Day 1, then 80mg on day 15 ☐ Inject 80mg SQ on Day 1, 2 and 15	Refill: 0
☐ Humira Maintenance ***Citrate free***	☐ 40mg/0.4ml PEN ☐ 40mg/0.4ml PFS ☐ 80mg/0.8ml PEN	☐ Inject 40mg SQ every-other-week (qty 2) ☐ Inject 80mg SQ every ____ week(s) (qty ____)	Refill:
☐ Simponi Induction	☐ 100mg PFS ☐ 100mg SmartJect	☐ Inject 200mg SQ at week 0, then 100mg at week 2 (qty 3)	Refill: 0
☐ Simponi Maintenance	☐ 100mg PFS ☐ 100mg SmartJect	☐ Inject 100mg every 4 weeks (qty 1)	Refill:
☐ Stelara	☐ 130mg Vial (Start) ☐ 90mg PFS (Maint.)	☐ Start: _____ mg IV at day 0 (qty _____) ***WEIGHT** _____ ☐ Maint: Inject 90mg SC at week 8, then every 8 weeks	Refill: 0 Refill:
☐ Xeljanz	☐ 5mg Tablet ☐ 10mg Tablet	☐ Start: 10mg twice daily: ☐ 8 weeks ☐ ____ weeks (qty 60) ☐ Maint: ☐ 5mg twice daily ☐ 10mg twice daily (qty 60)	Refill: 0 Refill:
☐ Zeposia	☐ Starter Pack (0.23mg/0.46mg Capsule)	☐ Take 0.23mg once daily on day 1 - 4 (qty 4), 0.46mg once daily on day 5 - 7 (qty 3)	Refill: 0
	☐ Starter Kit (0.23mg/ 0.46mg/0.92mg Capsule)	☐ Take 0.23mg once daily on day 1 - 4 (qty 4), 0.46mg once daily on day 5 - 7 (qty 3), 0.92mg once daily on day 8 and thereafter (qty 30)	Refill: 0
	☐ Maintenance (0.92mg Capsule)	☐ 0.92mg once daily (qty 30)	Refill:

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

How to start PA

- Complete enrollment form for specific medication
- Complete Apex form
- Scan enrollment forms into chart
- Fax enrollment forms to drug company and Apex with chart notes/labs/insurance info
- Start T bean in chart
- Notate if waiting on labs or if forms were faxed
- Send T bean to Danielle Clark

How to submit PA

- Apex portal/Fax enrollment form
- Cover My Meds
- BlueKC
- TricareWest
- Insurance specific form
  - Magellen
  - US RX Care
  - Archimedes

Appeals

- Fax denial to drug company
  - This can initiate/continue free drug program for commercial patients
- Once a medication has been denied, I review denial letter and send to provider why it was denied
- Appeal if requested

- **AOR** (Appointment of Representative)
  - Signature from patient allowing us to appeal on their behalf
  - Specific insurances request
    - Medicaid
    - Humana
    - INS will not accept appeal without this form is required

Appeal process

- Can take up to 30 days (or longer)
  - I will create action to check status of appeal and update patient
  - Once response received, will send to drug company
  - Will submit second appeal if INS allows
- If free drug program not available, will discuss with patient/provider to move forward for patient assistance

Patient assistance

- Humira/Skyrizi/Botox
  - Abbvie
  - Enrollment specific for each

  Cosentyx
  - Novartis

  Tremfya/Stelara
  - Johnson and Johnson
  - Enrollment specific for each

- Otezla
  - Amgen

  - Taltz
    - Lilly Cares

    - Dupixent
      - Dupxient Myway (No new enrollment form)

PAP

- Based off of household income
- Varies per company
- Medicare
  - High copays
  - Can complete high out of pocket cost form if income is too high for assistance

Botox

- **Abbvie assistance**
- All hyperhidrosis
  - Requires medical and prescription denials

  difficult to obtain

Medical benefits at specialty pharmacy

- depends on INS
- Accredo and OptumRX
- Us Bioservices

Botox Savings Program

- Patient to pay out of pocket
  - Will be considered "cosmetic" self pay
  - We supply Botox

- https://www.botoxsavingsprogram.com/
- **The BOTOX® Savings Program helps eligible patients receive money back on any out-of-pocket costs not covered by insurance.**
- **Patients whose insurance does not cover Botox can apply for the savings program online at link listed above. Eligible patients are those who have a diagnosis of chronic migraines or hyperhidrosis of axilla (not hands or feet) and do not have government-based insurance and are 18 years or older.**
- **Program Terms, Conditions, and Eligibility Criteria:**
- **1. Offer good only with a valid prescription for BOTOX®**
- **2. Based on insurance coverage, reimbursement may be up to $1000 per treatment with a maximum savings limit of $4000 per year; patient out-of-pocket expense may vary.**
- **3. Offer not valid for patients enrolled in Medicare, Medicaid, TRICARE or any other government-reimbursed healthcare program**
- **4. Offer valid for up to 5 treatments over a 12-month period.**
- **5. Claims must be submitted within 180 days of treatment date and must include a copy of (a) an Explanation of Benefits (EOB) for the BOTOX® treatment, (b) a Specialty Pharmacy (SP) receipt for BOTOX®, or (c) other writing showing payment of out-of-pocket BOTOX® and treatment-related out-of-pocket costs.**
- **6. A BOTOX® Savings Program check will be provided upon approval of a claim and may be sent either directly to you or to your authorized healthcare provider who provided treatment. For payment to be made to your healthcare provider, an authorized assignment of benefit also must be included with the Claim. Assigning your BOTOX® Savings Program benefit to your healthcare provider is not required to participate in the program.**

Botox Tricare

- PA needed for office visit with provider for medication and injection
  - J0585 Botox medication
  - 64650 Injection code
  - Needed for EACH appointment
- PA needed for dispensing pharmacy
  - J0585 Botox (use in units not vials)
    - 100/200 units
    - US Bioservices for Tricare