Genefic
SPECIALTY PHARMACY

To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: _____

Email: _____

Direct Phone Line: _____

Cell (optional, but preferred): _____

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Adalimumab Biosimilar Hadlima Hulio Hyrimoz Enrollment Form

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	**Fax:**
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐ **Yes Start Date:** ____/____/_____ ☐ **No** | **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions & Quantity	Refills
Hadlima™	☐ 40 mg/0.8 mL PushTouch Autoinjector ☐ 40 mg/0.4 mL PushTouch Autoinjector ☐ 40 mg/0.8 mL Pre-filled Syringe ☐ 40 mg/0.4 mL Pre-filled Syringe	**INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** ☐ **PSORIASIS/UVEITIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐ **CROHN'S/UC/HS:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** **MAINTENANCE DOSES:** ☐ Inject 40 mg SQ every **other** week (Quantity: 2) ☐ Inject 40 mg SQ weekly (Quantity: 4) ☐ Inject 80 mg SQ every **other** week (Quantity: 4)	
Hulio®	☐ 40 mg/0.8 mL Pen ☐ Pre-filled Syringe ☐ 40 mg/0.8 mL ☐ 20 mg/0.4 mL	**INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** ☐ **PSORIASIS/UVEITIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐ **CROHN'S/UC/HS:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** ☐ **PEDIATRIC CROHN'S:** Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: QS 28 days) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** **MAINTENANCE DOSES:** ☐ Inject 40 mg SQ every **other** week (Quantity: 2) ☐ Inject 40 mg SQ weekly (Quantity: 4) ☐ Inject 80 mg SQ every **other** week (Quantity: 4) ☐ Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	
Hyrimoz®	☐ Psoriasis Starter Package ☐ Crohn's/UC/HS Starter Package ☐ Pediatric Crohn's Starter Package ☐ 80 mg/0.8 mL Pre-Filled Syringe ☐ 80 mg/0.8 mL and 40 mg/0.4 mL Pre-Filled Syringe ☐ 40 mg/0.4 mL Sensoready® Pen ☐ 80 mg/0.8 mL Sensoready® Pen ☐ 40 mg/0.4 mL Pre-filled Syringe ☐ 20 mg/0.2 mL Pre-filled Syringe ☐ 10 mg/0.1 mL Pre-filled Syringe	**INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** ☐ **PSORIASIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: QS 28 days) ☐ **CROHN'S/UC/HS:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: QS 28 days) ***Intended for ped CD patients ≥ 40 kg (88 lbs)*** ☐ **PEDIATRIC CROHN'S:** Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: QS 28 days) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** **MAINTENANCE DOSES:** ☐ Inject 40 mg SQ every **other** week (Quantity: 2) ☐ Inject 40 mg SQ weekly (Quantity: 4) ☐ Inject 80 mg SQ every **other** week (Quantity: QS 28 days) ☐ Inject 10 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)*** ☐ Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ H20.9 Iridocyclitis (Uveitis), unspecified
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ L73.2 Hidradenitis suppurativa
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, unspecified
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M08.09 Unspecified juvenile RA, multiple sites (pcJIA)
☐ M45.9 Ankylosing Spondylitis, unspecified
☐ Other: _____

Date of Diagnosis: _____/_____/_____ **Allergies:** _____

Active TB is ruled out: ☐ Yes ☐ No Date: ____/____/____ Hep B ruled out/treated: ☐ Yes ☐ No Date: ____/____/____

Additional Clinical Information:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ enefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing enefic to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE