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

Adalimumab Biosimilar Idacio Yuflyma Yusimry 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
Idacio®	☐ Psoriasis/Uveitis Starter Package ☐ Crohn's/UC Starter Package ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.8 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:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 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)	
Yuflyma®	☐ 40 mg/0.4 mL Autoinjector	**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 ≥ 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)	
Yusimry™	☐ 40 mg/0.8 mL Pen	**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 ≥ 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)	

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

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.