DERMATOLOGY REFERRAL FORM

Jersey Shore Pharmacy

580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ Date of Birth _____
☐ Male ☐ Female SS# _____ Language _____
Address _____ Apt # _____
City _____ State _____ ZIP _____
Phone _____ Cell _____ Email _____
Allergies _____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name _____
Relation to Patient _____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Phone _____ Fax _____
Policy/Group# _____
Bin# _____ Pcn# _____
RXID# _____ RX Group# _____

ICD-10 Code: ☐ L40.59 Psoriatic Arthritis ☐ L40.8 Psoriasis ☐ L73.2 Hidradenitis Suppurativa ☐ Other _____
Location ☐ Scalp ☐ Groin ☐ Nails ☐ Other _____ Severity ☐ Mild (<3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (>10% BSA)
Patient currently on therapy? ☐ Yes ☐ No PPD Test ☐ Yes ☐ No Results _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

XELJANZ® ☐ 5 mg tablet **XELJANZ XR®** ☐ 11 mg tablet
Psoriatic Arthritis ☐ 5 mg twice daily OR ☐ 11 mg once daily used in combination with nonbiologic DMARDs
Other: _____ QTY: _____ Refills: _____

TREMFYA ☐ Prefilled Syringe 100mg/mL QTY: _____ Refills: _____
☐ **Starting Dose:** 100 mg SQ injection at wk 0 & wk 4 ☐ **Maint Dose:** 100 mg SQ injection given every 8 wks thereafter

STELARA™ ☐ 45mg PFS ☐ 90mg PFS
☐ Patients weighing <100kg (220lbs): Inject 45mg SQ initially & 4 weeks later, followed by 45mg every 12 weeks
☐ Patients weighing > 100kg (220lbs): Inject 90mg SQ initially & 4 weeks later, followed by 90mg every 12 weeks
☐ Other: _____ QTY: _____ Refill: _____

COSENTYX ☐ Sensoready® Pen ☐ Prefilled Syringe
Starting Dose *Weeks 0, 1, 2, 3, and 4, then once every 4 weeks*
SIG: ☐ Inject 300mg dose SQ once wkly for 5 wks ***Each 300 mg dose is given as 2 SQ injections of 150 mg*** QTY: 10 injection devices Refills: 0
☐ Inject 150mg dose SQ once weekly for 5 weeks QTY: 5 injection devices Refills: 0
Maintenance Supply *Once every 4 weeks*
SIG: ☐ Inject 300 mg dose SQ once every 4 weeks ***Each 300 mg dose is given as 2 SQ injections of 150 mg***
☐ Inject 150mg dose SQ every 4 weeks QTY: 1 injection device Refills: 0
☐ Other: _____
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY: _____ Refill: _____

SIMPONI™ ☐ SmartJect™ Autoinjector ☐ PFS 50mg/0.5mL QTY: _____ Refill: _____
☐ **Starting Dose:** 200mg SQ at week 0, then 100mg SQ at week 2 QTY: 3 (100 mg/mL)
Maintenance: ☐ 100mg SQ every 4 wks QTY: 1 (100 mg/mL) | ☐ 50mg SQ every 4 weeks QTY: 1 (50 mg/0.5mL)
☐ Psoriasis Arthritis Dose: Inject 50 mg (0.5ml) SQ once a month ☐ Other: _____

OTEZLA® ☐ Titration Starter Pack ☐ Tablets
☐ Take As Directed* *These directions can only be selected for the Titration Starter Pack QTY: 27 Refill: _____
☐ Take 30 mg once daily QTY: 30 Refill: _____
☐ Take 30 mg twice daily QTY: 60 Refill: _____

DUPIXENT® ☐ 300 mg/2 mL solution in a single-dose PFS QTY: _____ Refill: _____
☐ Initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week

HUMIRA *PSORIASIS*
☐ **Starting Dose:** Inject two 40 mg pens/syringes SQ on day 1, then one 40mg on day 8, then one 40mg every other week
QTY 4 NO REFILLS
☐ **Maintenance Dose:** 40 mg SQ every other week QTY: 2 Refill: _____
HUMIRA *HIDRADENITIS SUPPURATIVA*
☐ **Starting Dose:** Inject 160mg (4 pens) on day 1 then inject 80mg (2 pens) on day 15
☐ **Maintenance Dose:** Inject 40mg SQ every week QTY: _____ Refill: _____

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriasis Start Dose: ☐ Inject 160mg SQ at week 0 followed by 80mg at weeks 2,4,6,8,10 & 12 QTY: 8 Refills: 0
Psoriatic Arthritis Start Dose: ☐ 160 mg SQ at wk 0, followed by 80 mg every 4 wks QTY: 2 Refills: _____
Maintenance SIG: ☐ Inject 80mg SQ every 4 weeks QTY: _____ Refills: _____
☐ Other: _____ QTY: _____ Refills: _____

ENBREL® (etanercept) QTY: _____ Refill: _____
☐ SureClick™ Autoinjector 50mg ☐ PFS 50mg ☐ Multiuse Vial 25mg ☐ PFS 25mg/0.5ml
☐ Psoriasis Induction Dose: Inject 50mg SQ TWICE a week (3-4 days apart) for 3 mo, then maint dosing
☐ Psoriasis Maintenance Dose: Inject 50mg SQ ONCE a week
☐ Psoriasis Arthritis Dose: Inject 50mg SQ ONCE a week
☐ Other _____

Prescriber's Name / Practice _____ Office Contact _____
Address _____ Suite# _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed form to **JERSEY SHORE PHARMACY** at **609.660.0101**

Visit us at **WWW.JERSEYSHORE.PHARMACY** for online fillable forms.