



Psoriasis Referral Form

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Patient Information		<input type="checkbox"/> New Rx	<input type="checkbox"/> Refill
Name	Date of Birth	Home Phone Number	Other Phone Number
Address		City	State Zip
Patient SS#	<input type="checkbox"/> Allergies		<input type="checkbox"/> No Known Allergies

Drug Delivery Info

Date Shipment Needed: Ship to: Patient Clinic

Insurance Info [Fax a copy of the patient's insurance card (both sides.)]

Doctor/Prescriber Info [NPI # is mandatory.]

Name: Office Contact:

Address: City: State: Zip:

NPI #: Phone #: Fax #:

Statement of Medical Necessity ** Please FAX recent clinical notes, tests, with the prescription to expedite the Prior Authorization.

Patient Weight: lbs. kg 696.1 Psoriasis 696 Psoriatic Arthritis

Indicate treatment failure or intolerance to the following drugs: Enbrel Humira Simponi Stelara Methotrexate PUVA UVB

Topicals (please list): Others (please list):

TB/PPD Test Given Date:

Medication	Dose/Strength	Sig	Qty	Refills
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/mL Sureclick® autoinjector <input type="checkbox"/> 50mg/ml prefilled syringes <input type="checkbox"/> 25mg/0.5ml prefilled syringes <input type="checkbox"/> 25mg vial	<input type="checkbox"/> Psoriasis Induction Dose: Inject 50 mg SC Twice a week (72-96 hours apart) x3 months <input type="checkbox"/> Maintenance Dose: Inject 50 mg SC once a week		
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8mL prefilled auto pen <input type="checkbox"/> 40mg/0.8mL prefilled syringes <input type="checkbox"/> Psoriasis Starter Pack	<input type="checkbox"/> Starter Pack: 80mg SC Day 1, then 40mg one week later (Day 8), then 40mg every other week thereafter <input type="checkbox"/> Maintenance Dose: 40mg SC every two weeks <input type="checkbox"/> Inject 40mg SC ONCE a week		
<input type="checkbox"/> Simponi® * Only for PsA	<input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml prefilled syringe	<input type="checkbox"/> Inject 50mg SC once a month		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5mL prefilled syringe <input type="checkbox"/> 90mg/1mL prefilled syringe	<input type="checkbox"/> Initiation Dose: Inject the contents of 1 prefilled syringe SC initially Day 1 <input type="checkbox"/> Maintenance Dose: Inject the contents of 1 prefilled syringe SC starting Day 29 & every 12 weeks thereafter		
<input type="checkbox"/> Oxsoresalen-Ultra®	<input type="checkbox"/> 10mg			
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg	<input type="checkbox"/> Day 1: 10 mg in morning <input type="checkbox"/> Day 2: 10 mg in morning and 10 mg in evening <input type="checkbox"/> Day 3: 10 mg in morning and 20 mg in evening <input type="checkbox"/> Day 4: 20 mg in morning and 20 mg in evening <input type="checkbox"/> Day 5: 20 mg in morning and 30 mg in evening <input type="checkbox"/> Day 6 and thereafter: 30 mg twice daily <input type="checkbox"/> 30mg sig: Take one tablet by mouth twice daily.		

Doctor/Prescriber Signature

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan. IMPORTANT CONFIDENTIALITY NOTICE: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity name above. He authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the content of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

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