Psoriasis Referral Form

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Patient Information

☐ New Rx ☐ Refill

Name | Date of Birth | Home Phone Number | Other Phone Number

Address | City | State | Zip

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

Doctor/Prescriber Signature

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