

DERMATOLOGY PATIENT REFERRAL FORM

Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician 1 st order only <input type="checkbox"/> Physician all orders <input type="checkbox"/> Other _____ <input type="checkbox"/> Educational Support Requested	
Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Patient Soc. Sec #: _____ Allergies: _____ Date of Birth: ____/____/____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight: ____ lbs ____ kg Patient ethnicity: _____ <input type="checkbox"/> See attached demographic sheet Height: _____ BSA _____ m ²	Physician Name: _____ State Lic #: _____ DEA #: _____ NPI #: _____ Specialty: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Physician Phone: (____) _____ - _____ Physician Fax: (____) _____ - _____ Nurse/Key Office Contact: _____

INSURANCE INFORMATION (Please Attach Copies of front and back of cards)

DIAGNOSTIC INFORMATION COMPLETE FIELDS BELOW AND ATTACH APPROPRIATE DOCUMENTS. Please Fax Concurrent Medication List to Grubb's NW Specialty Pharmacy

L40.50 Arthropathic Psoriasis, unspecified L40.59 Other Psoriatic Arthropathy L40.9 Psoriasis Other: _____

Location of psoriasis: Hand Feet Face Scalp Groin Nails Others: _____

Severity of psoriasis: Mild (up to 3% BSA) Moderate (3-10% BSA) Severe (greater than 10% BSA) BSA _____ %

Has patient received a PPD (tuberculosis) Skin Test? Yes No Results: _____ Date: _____

Has this patient been treated for this condition previously with systemic therapy or phototherapy? Yes No
 Medication(s): _____ Phototherapy _____

Is this patient currently on therapy? Yes No Medication(s): _____

Will patient stop taking the above medication(s) before starting the new medication? Yes No If yes, how long should patient wait before starting the new medication? _____

<input type="checkbox"/> Skyrizi® <input type="checkbox"/> Starting dose: Inject 150mg SQ at week 0 and week 4 <input type="checkbox"/> Maintenance dose: Beginning week 16, inject 150mg SQ every 12 weeks QTY: _____ REFILLS: _____ <input type="checkbox"/> Humira® <input type="checkbox"/> Pen <input type="checkbox"/> PFS Citrate Free? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Starter Kit QTY: <u>1</u> REFILLS: <u>0</u> SIG: <input type="checkbox"/> Inject 80mg SQ on day 1, then 40mg SQ on day 8, then begin maintenance dose. <input type="checkbox"/> Maintenance Kit QTY: _____ REFILLS: _____ SIG: <input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Other _____ SIG: _____ QTY: _____ REFILLS: _____ <input type="checkbox"/> Other _____ SIG: _____ QTY: _____ REFILLS: _____	<input type="checkbox"/> Cosentyx® <input type="checkbox"/> 150mg/1ml Pen <input type="checkbox"/> 150mg/1ml PFS <input type="checkbox"/> 300mg/2ml Pen <input type="checkbox"/> 300mg/2ml PFS SIG: <input type="checkbox"/> Starting Dose: Inject SQ <u>weekly</u> for 5 weeks QTY: 5 REFILLS: 0 SIG: <input type="checkbox"/> Maintenance Dose: Inject SQ <u>once</u> a month QTY: _____ REFILLS: _____ <input type="checkbox"/> Otezla® <input type="checkbox"/> Enroll in BRIDGE RX(see back) <input type="checkbox"/> 2 Week Starter Pack Dispensed by Prescriber Titration Start Date: _____ <input type="checkbox"/> 4 Week Starter Pack QTY: 1 REFILLS: 0 <input type="checkbox"/> Maintenance Dose: 30 mg twice daily QTY: _____ REFILLS: _____ <input type="checkbox"/> Tremfya™ 100mg/ml PFS SIG: <input type="checkbox"/> Starting Dose: 100 mg SQ, week 0 QTY: 1 REFILLS: 0 SIG: <input type="checkbox"/> 2nd dose: 100 mg SQ, week 4 QTY: 1 REFILLS: 0 SIG: <input type="checkbox"/> Maintenance Dose: 100mg SQ every 8 weeks QTY: _____ REFILLS: _____	<input type="checkbox"/> Stelara™ If patient's weight ≤ 220lbs <input type="checkbox"/> 45 mg PFS <input type="checkbox"/> 45 mg/0.5 ml vial If patient's weight ≥ 220lbs <input type="checkbox"/> 90 mg PFS <input type="checkbox"/> 90 mg/ml vial SIG: <input type="checkbox"/> Starting Dose: Inject SQ initially (week 0) QTY: 1 REFILLS: 0 SIG: <input type="checkbox"/> then Inject SQ, on week 4 QTY: 1 REFILLS: 0 SIG: <input type="checkbox"/> Maintenance Dose: Inject SQ every 12 weeks QTY: 1 REFILLS: _____ <input type="checkbox"/> Taltz™ <input type="checkbox"/> 80mg/ml Pen <input type="checkbox"/> 80mg/ml PFS SIG: <input type="checkbox"/> Inject 160mg (2 doses) SQ on <u>week 0</u> QTY: 2 REFILLS: 0 <input type="checkbox"/> then Inject 80mg SQ once <u>every 4 weeks</u> QTY: 1 REFILLS: _____ For patients with coexistent moderate-to-severe plaque psoriasis, <input type="checkbox"/> Inject 160mg (2 doses) SQ on <u>week 0</u> , then Inject 80mg SQ on <u>weeks 2,4,6,8,10 and 12</u> QTY: 8 REFILLS: 0 <input type="checkbox"/> then Inject 80mg SQ once <u>every 4 weeks</u> QTY: 1 REFILLS: _____
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Prescriber Prior Authorization Consent: Physician hereby authorizes the Pharmacy, as agent for Physician, to perform any of the following services on behalf of Physician for this Patient: To obtain prior authorization from applicable PBMs or other payors for drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other patient information; to conduct benefits investigations; and to conduct eligibility investigations. In furtherance of the Pharmacy providing the above services, Physician agrees to provide or make available to the Pharmacy from time to time such information regarding patient's treatment as might be requested by payor.

I certify that I am prescribing the drug(s) listed above. I authorize the Pharmacy to perform the above services on behalf of Physician for the benefit of the Patient.

Physician's Signature: _____ DAW (Dispense as Written) Date ____/____/____
 Prescriber certifies that this referral form contains an original signature and is signed by the treating physician

Rep: _____

DERMATOLOGY PATIENT REFERRAL FORM



1517 17th Street NW, Washington DC 20036

Phone: 202-503-2644 | Fax: 202-503-1721

Our PA Team is here to help!

Here is our contact information:

Main number: (202) 503-2644 | Fax number: (202) 503-1721

- To check the status of **pending PA's**, call **Angela** at ext.225

❖ **Please forward to us any updates you receive from the insurance company regarding approvals or denials**

Bridge Rx — 30 mg of Otezla†

TWICE DAILY (Recommended daily dose) x14 days 28 tablets 12 refills

ONCE DAILY (For patients with severe renal impairment) x28 days 28 tablets 6 refills

† Bridge Rx is at no cost, for eligible commercially insured, on-label diagnosed patients only, and not contingent on purchase requirements of any kind. Bridge Rx is not available to enrollees in Medicare, Medicaid, and other federal and state programs, as well as Massachusetts residents. Intended to support continuation of prescribed therapy if there is a delay in determining whether commercial prescription coverage is available

www.grubbsnw.com

Rep: _____