DERMATOLOGY PATIENT REFERRAL FORM

Ship to: ❑Patient ❑Physician 1st order only ❑Physician all orders ❑ Other_____ ❑Educational Support Requested

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Patient Soc. Sec #: _____ Allergies: _____
Date of Birth: ___/___/_____ Sex: ❑Male ❑Female Weight: ____lbs ____kg
Patient ethnicity: _____
❑ 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? _____

☐ **Cimzia®**

❑ **Recommended dose:**
2 Syringes(400mg) SQ, every other week

❑ **Alternate dose** (Can be considered for some patients with body weight ≤90kg)**:**
2 Syringes(400mg) SQ weeks 0, 2, 4, then
1 Syringe(200mg) SQ, every other week

QTY:_____ **REFILLS:**_____

☐ **Humira®**

❑ **Pen** ❑ **PFS** | **Citrate Free? ❑YES ❑NO**

❑ **Starter Kit QTY:** 1 **REFILLS:** 0
SIG: ❑ Inject 80mg SQ on day 1, then 40mg SQ on day 8, then begin maintenance dose.

❑ **Maintenance Kit QTY:**_____ **REFILLS:**_____
SIG: ❑ Inject 40mg SQ every other week

☐ **Other** _____
SIG: _____
QTY:_____ **REFILLS:**_____

☐ **Cosentyx®**

❑ 150mg/1ml Pen ❑ 150mg/1ml PFS
❑ 300mg/2ml Pen ❑ 300mg/2ml PFS
SIG:❑ *Starting Dose:* Inject SQ weekly for 5 weeks
QTY: 5 **REFILLS: 0**

SIG:❑ *Maintenance Dose:* Inject SQ once a month
QTY:_____ **REFILLS:**_____

☐ **Otezla®** ☐ **Enroll in BRIDGE RX***(see back)*

❑ 2 Week Starter Pack Dispensed by Prescriber
Titration Start Date:_____
❑ 4 Week Starter Pack
QTY: 1 **REFILLS: 0**
❑ Maintenance Dose: 30 mg twice daily
QTY:_____ **REFILLS:**_____

☐ **Tremfya™ 100mg/ml PFS**

SIG :❑ *Starting Dose:* 100 mg SQ, week 0
QTY: 1 **REFILLS: 0**
SIG :❑ *2nd dose:* 100 mg SQ, week 4
QTY: 1 **REFILLS: 0**

SIG:❑ *Maintenance Dose:* 100mg SQ every 8 weeks
QTY:_____ **REFILLS:**_____

☐ **Stelara™**

If patient's weight ≤ 220lbs
❑ 45 mg PFS ❑45 mg/0.5 ml vial
If patient's weight ≥ 220lbs
❑ 90 mg PFS ❑90 mg/ml vial
SIG:❑ *Starting Dose:* Inject SQ initially (week 0)
QTY: 1 **REFILLS: 0**

SIG:❑ then Inject SQ, on week 4
QTY: 1 **REFILLS: 0**

SIG:❑ *Maintenance Dose:* Inject SQ every 12 weeks
QTY: 1 **REFILLS:** _____

☐ **Taltz™**

❑ 80mg/ml Pen ❑ 80mg/ml PFS
SIG:❑ Inject 160mg (2 doses) SQ on week 0
QTY: 2 **REFILLS: 0**
❑ then Inject 80mg SQ once every 4 weeks
QTY: 1 **REFILLS:**_____

For patients with coexistent moderate-to-severe ***plaque psoriasis****,*
❑ Inject 160mg (2 doses) SQ on week 0, *then*
Inject 80mg SQ on weeks 2,4,6,8,10 and 12
QTY: 8 **REFILLS: 0**

❑ then Inject 80mg SQ once every 4 weeks
QTY: 1 **REFILLS:**_____

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:_____

Revised: 12/14/2018

DERMATOLOGY PATIENT REFERRAL FORM

GRUBB'S NW
SPECIALTY PHARMACY

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 on status of ***pending PA's***, call **Angela** at ext.225

- ***All other questions***, call **Dawn** at ext. 221 or **Nick** at ext. 218

❖ ***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:____

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