DELMARVA SPECIALTY PHARMACY AT WOODBROOKE

PSORIASIS REFERRAL FORM

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Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Dec 2017

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

Diagnosis ☐ L40.8 Psoriasis ☐ Other ICD-10 Code Location ☐ Scalp ☐ Groin ☐ Nails ☐ Other Allergies

Severity ☐ Mild (<3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (>10% BSA) Patient currently on therapy? ☐ Yes ☐ No PPD Test ☐ Yes ☐ No Results

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

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:

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriasis Start Dose: ☐ Inject 160mg SQ at wk 0 followed by 80mg at wks 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: ☐ Inject 80mg SQ every 4 weeks QTY: Refills:
☐ Other: QTY: Refills:

TREMFYA **Prefilled Syringe 100mg/mL**
☐ Initial dose of 100 mg SQ injection at week 0 and week 4
☐ Maint Dose: 100 mg SQ injection given every 8 weeks thereafter QTY: Refills:

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

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

OTEZLA® ☐ Titration Starter Pack SIG: Take as directed QTY 55 for 28 days
☐ Maintenance: 30 mg SIG: Take 30mg twice a day QTY 60 Refills

ENBREL 50 mg/ml *not to be used in pediatric weighing less than 63 kg (138 lbs)*
☐ *SureClick (prefilled autoinjector)* ☐ PFS *(prefilled syringes)*
Starting Dose: ☐ 50 mg SQ BIW *(72-96 hours apart)* QTY 8 Refills
*Psoriasis: The recommended starting adult dose is for 3 months *(Max of 2 refills), please specify number of refills*
Maintenance Dose: ☐ 50 mg SQ weekly QTY 4 Refills

ENBREL 25 mg/ml *not to be used in pediatric weighing less than 31 kg (68 lbs)* QTY 8 Refills
☐ 25 mg Multiple-Use ☐ Vial 25 mg SQ BIW *(72-96 hrs apart)* ☐ 25 mg/0.5 ml PFS (Prefilled Syringes)

STELARA **Starting Dose:** ☐ 45 mg ☐ 90mg SQ initially & weeks 4 later
Maintenance Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion Infusion supplies needed ☐ YES ☐ NO
Starting Dose: ☐ 5 mg/kg ____mg on week 0, week 2 & week 6 then,
Maintenance Dose: ☐ 5 mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
Other QTY Refills

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 Refills

HUMIRA ***Hidradenitis Suppurativa***
Starting Dose: ☐ Inject four 40 mg pens/syringes SQ on day 1 OR inject two 40 mg pen/syringes daily for 2 days, THEN two 40mg pens/syringes on day 15, QTY 6 NO REFILLS
Maint. Dose: ☐ 40 mg SQ every wk, beginning day 29 QTY Refills

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

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

Please fax completed referral form to **Delmarva Specialty Pharmacy** at **410.677.0562** Visit us at **WWW.DELMARVAPHARMACY.COM** for online fillable forms.