



PSORIASIS REFERRAL FORM

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Today's Date

NEW PATIENT CURRENT PATIENT

Aug 2018

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 subcutaneously initially & 4 weeks later
Maintenance Dose: 45 mg 90mg subcutaneously 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 _____

Psoriasis **HUMIRA**® **HUMIRA**® Citrate-Free 40mg/0.8mL 80mg/0.8mL | PFS Pens
Starting Dose: Inject 160 mg dose pens/syringes subcutaneously on day 1, then one 40mg on day 8, then one 40mg every other week QTY 4 NO REFILLS
Maintenance Dose: 40 mg subcutaneously every other week QTY 2 Refills _____

Hidradenitis Suppurativa **HUMIRA**® **HUMIRA**® Citrate-Free 40mg/0.8mL 80mg/0.8mL | PFS Pens
Starting Dose: Inject 160 mg dose pens/syringes subcutaneously on day 1 OR inject 80 mg dose pen/syringes daily for 2 days, THEN 80mg dose pens/syringes on day 15, QTY 6 NO REFILLS
Maint. Dose: 40 mg subcutaneously every week, 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** _____

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