Dermatology (A M) Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535   Fax: 877 326 2856

V.07.10.17.A

Patient Demographics

Name: ____________________ ☐M ☐F
DOB: __________ SS#: __________
Phone: __________ 2nd Phone: __________
Address: ____________________
City: __________ State: ______ Zip: ______
Primary language, if other than English: __________

****Please fax a copy (front and back) of the patient's insurance card as well as any relevant clinical notes/documents****

Provider Information

Prescriber: ____________________
____
Phone: __________ Fax: __________
Address: ____________________
____
NPI: __________ Office contact: __________
This is a: ☐New Rx ☐Refill
Training by: ☐Prescriber's office ☐Pharmacy to facilitate ☐Not needed
Deliver first fill to: ☐Prescriber's office ☐Patient ☐Other: ______

Clinical Information

Diagnosis:
☐ Psoriasis vulgaris (L40.0)
☐ Other psoriasis (L40.8)
☐ Psoriasis, unspecified (L40.9)
☐ Psoriatic arthritis (L40.5)
☐ Hidradenitis suppurativa (L73.2)
☐ Other: __________

BSA affected(%): __________
List areas affected: __________
____
Prior treatments & reason for discontinuation:
____
____
____

Date of negative TB test: __________
☐TB test pending, will fax results
HBV negative or treated: ☐Yes ☐No
Patient weight: ______ Height: ______
Allergies: __________
____
Other notes: __________

AAD Consensus Statement on Psoriasis Therapies:
☐Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationship.
☐Psoriasis is covering greater than 10% of BSA. ☐Psoriasis is on palms, soles, head and neck, or genitalia. ☐Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints.

Prescription Information

Medication	Directions		Quantity	Refills
☐Cosentyx 150mg (secukinumab)	Induction:	☐Inject 300mg SQ at weeks 0, 1, 2, and 3.	8 pens/syringes	Zero
		☐Inject 150mg SQ at weeks 0, 1, 2, and 3.	4 pens/syringes	Zero
	Maintenance:	☐Beginning week 4, inject 300mg SQ once every 4 weeks.	☐2 pens/syringes	
		☐Beginning week 4, inject 150mg SQ once every 4 weeks.	☐1 pen/syringe	
	☐Other: ______		☐Other: ______	______
☐Enbrel 50mg ☐Enbrel 25mg (etanercept)	☐Induction: Inject 50mg SQ twice weekly for 12 weeks (3 months).		24 pens/syringes	Zero
	☐Maintenance: Inject 50mg SQ once weekly.		☐4 pens/syringes	
	☐Other: ______		☐Other: ______	______
☐Humira 40mg (adalimumab)	Induction:	☐Psoriasis: Inject 80mg SQ on day 0, 40mg SQ on day 7, then 40mg SQ every OTHER week thereafter.	4 pens/syringes	Zero
		☐Hidradenitis Suppurativa: Inject 160mg SQ on day 0, 80mg SQ on day 14, then 40mg SQ weekly thereafter beginning on day 28.	6 pens/syringes	Zero
	Maintenance:	☐Inject 40mg SQ once weekly.	☐4 pens/syringes	
		☐Inject 40mg SQ every OTHER week.	☐2 pens/syringes	
		☐Other: ______	☐Other: ______	______
☐Other Medication Drug: Dose:	Directions:		Quantity:	Refills:

Please note, to increase adherence and patient acceptance all medications will be dispensed as pen-type injectors unless unavailable or otherwise specified.

Provider Signature: ______________________ **Date:** __________

My signature for this prescription also authorizes OptiMed Pharmacy and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.

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Additional Information/Notes for the Pharmacy: