Dermatology (N Z) Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856

OptiMed SPECIALTY PHARMACY

V.07.20.17.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
☐Orencia® 125mg (abatacept)	☐Inject 125mg SQ once weekly.	4 pens/syringes	_____
☐Otezla® 30mg (apremilast)	☐Titration Starter Pack: Take as directed per package.	28-day starter pack	Zero
	☐14-day starter pack **already given to patient**. Date provided: _____	N/A	N/A
	☐Take 30mg PO BID.	☐60 tablets	
	☐Take 30mg PO once daily (severe renal impairment).	☐30 tablets	_____
☐Simponi® 50mg (golimumab)	☐Inject 50mg SQ once monthly.	☐1 pen/syringe	
	☐Other:_____	☐Other:_____	_____
☐Stelara® (ustekinumab)	☐Weight ≤ 100kg: 45mg ☐Weight >100kg: 90mg Induction: Inject 1 syringe SQ on day 0.	1 syringe	Zero
	☐Maintenance: Beginning on day 28, inject 1 syringe every 12 weeks.	1 syringe	_____
☐Taltz® 80mg* (ixekizumab)	***OptiMed will facilitate the PA process for Taltz referrals. Once approved, the referral will be transferred to a Taltz contracted specialty pharmacy.**		
	Induction: ☐Weeks 0-2: Inject 160mg SQ at week 0 and 80mg SQ at week 2.	3 pens/syringes	Zero
	☐Weeks 4-10: Beginning week 4, inject 80mg SQ once every OTHER week until week 12.	2 pens/syringes	1 refill
	Maintenance: ☐Beginning week 12, inject 80mg SQ once every 4 weeks.	☐1 pen/syringe ☐Other:_____	_____
☐Tremfya® 100mg (guselkumab)	Induction: ☐Inject 100mg SQ at week 0.	1 syringe	Zero
	Maintenance: ☐Beginning week 4, inject 100mg SQ once every 8 weeks.	1 syringe	_____
☐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.

Additional Information/Notes for the Pharmacy: