Elwyn SPECIALTY CARE
A BIOMATRIX Company

FEB 2018

PSORIASIS REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name ______ SS# ______ DOB ______ ☐ Male ☐ Female
Street Address ______ Apt# ______ City ______ State ______ Zip ______
Daytime Tel ______ Cell ______ Email ______ Height ______ Weight ______ BSA ______
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone ______
Allergies ______ Comorbidities ______
Current Medications (if necessary, please fax a complete list) ______

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION
______	______	______	______
______	______	______	______
______	______	______	______

REFERRAL SOURCE INFORMATION

☐ ______ # ______	☐ ______ # ______	☐ ______ # ______
☐ ______ # ______	☐ ______ # ______	☐ ______ # ______
☐ ______ # ______	☐ ______ # ______	☐ ______ # ______
☐ ______ # ______	☐ ______ # ______	☐ ______ # ______
☐ ______ # ______	☐ ______ # ______	☐ ______ # ______

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# ______

ICD-10 Diagnosis Code ☐ L40.59 Psoriatic Arthritis ☐ L40.8 Psoriasis ☐ L73.2 Hidradenitis Suppurativa ☐ Other ______
Location: ☐ Scalp ☐ Groin ☐ Nails ☐ Other______ Patient currently on therapy? ☐ Yes ☐ No
Severity: ☐ Mild (<3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (>10% BSA)
PPD Test: ☐ Yes ☐ No Results______

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:______

TREMFYA **Prefilled Syringe 100mg/mL** QTY: ______ Refills: ______
☐ **Starting Dose:** 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 8 weeks thereafter

COSENTYX ☐ Sensoready® Pen ☐ Prefilled Syringe
Starting Dose: *Weeks 0, 1, 2, 3, and 4, then once every 4 weeks*
SIG: ☐ Inject 300 mg dose SQ once weekly for 5 wks
QTY: 10 injection devices Refills: 0
Each 300 mg dose is given as 2 SQ injections of 150 mg
Maintenance Supply: *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® **Prefilled Syringe 300mg/2mL**
☐ **Starting Dose:** 600 mg (two 300 mg injections in different injection sites)
☐ **Maintenance Dose:** 300 mg given every other week
QTY: ______ 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 | *(Maximum 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)*
☐ 25 mg/0.5 ml PFS (PreFilled Syringes) ☐ 25 mg Multiple-Use
☐ Vial 25 mg SQ BIW *(72-96 hours apart)*
QTY: 8 Refills ______

SIMPONI
Dose: SmartJect™ ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL
SIG: ☐ inject 50mg SQ monthly QTY______ Refills ______

SILIQ **Prefilled Syringe 210mg/1.5 mL**
☐ **Starting Dose:** Inject 210 mg SQ at weeks 0, 1 & 2 then maintenance QTY: 3
☐ **Maintenance Dose:** Inject 210 mg SQ every 2 weeks 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 160mg (4 pens) on day 1, then inject 80mg (2 pens) on day 15 QTY: ______ Refills: ______
Maintenance Dose: ☐ Inject 40mg SQ every week QTY: ______ Refills: ______

OTEZLA® ☐ 28 day Titration Starter Pack ☐ Tablets
☐ Take as directed *These directions can only be selected for the Titration Starter Pack* QTY: 55 Refills ______
☐ Take 30 mg once daily QTY: 30 Refills ______
☐ Take 30 mg twice daily QTY: 60 Refills ______

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion
Infusion Supplies: ☐ YES ☐ NO
☐ **Initial Dose:** Infuse ____mg IV at weeks 0, 2 & 6 QTY______
☐ **Maintenance Dose:** Infuse ____mg IV every 8 weeks thereafter
QTY______ Refills ______

STELARA **Starting Dose:** ☐ 45 mg ☐ 90mg SQ initially & 4 weeks later QTY: 2
Maint. Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks QTY: ____ Refills: ____

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriasis Starting Dose SIG: ☐ Inject 160mg SQ at week 0 followed by 80mg at weeks 2,4,6,8,10 and 12 QTY: 8 Refills: 0
Psoriatic Arthritis Starting Dose SIG: ☐ 160 mg SQ at week 0, followed by 80 mg every 4 weeks QTY: 2 Refills:______
Maintenance ☐ Inject 80mg SQ every 4 wks QTY:____ Refills:______
☐ Other: ______ QTY: ______ Refills: ______

OTHER ______
Sig ______ Qty ______ Refills ______

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care 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**______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH PSORIASIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Recent TB test results and date if applicable
- ☐ Previous treatment
- ☐ Severity of disease
- ☐ BSA Sheet
- ☐ Documentation of phototherapy
- ☐ Clinical notes

Fax the requested documentation to (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) Direct Phone: (610) 545-6040

ElwynSpecialtyCare.com

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