

**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**

July 2017

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**

<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

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**

**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: \_\_\_\_\_

**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 wk QTY:4 NO REFILLS  
**Maint. Dose:**  40 mg SQ every other week QTY: 2 Refills \_\_\_\_\_

**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: \_\_\_\_\_

**HUMIRA HIDRADENITIS SUPPURATIVA**  
**Initial Dose:**  Inject 160mg (4 pens) on day 1, then inject 80mg (2 pens) on day 15 QTY: \_\_\_\_\_ Refills: \_\_\_\_\_  
**Maint. 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 \_\_\_\_\_

**DUPIXENT® Prefilled Syringe 300mg/2mL**  
 Initial dose of 600 mg (two 300 mg injections in different injection sites)  
 Maint Dose: 300 mg given every other week  
 QTY: \_\_\_\_\_ 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 wks QTY: \_\_\_\_\_ Refills: \_\_\_\_\_

**SIMPONI**  
 Dose: SmartJect™  50mg/0.5mL | Prefilled Syringe  50mg/0.5mL  
 SIG:  inject 50mg SQ monthly 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 \_\_\_\_\_

**TALTZ 80mg**  Autoinjector  Prefilled Syringe  
**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  
**Maintenance**  
 SIG:  Inject 80mg SQ every 4 weeks QTY: \_\_\_\_\_ Refills: \_\_\_\_\_  
 Other: \_\_\_\_\_ QTY: \_\_\_\_\_ 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 \_\_\_\_\_

**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.



# 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***

**Elwyn**  
**SPECIALTY CARE**  
Part of The Elwyn Pharmacy Group  
***Dedicated to Improving***  
***Our Patients' Health***

