Pharmax SPECIALTY PHARMACY

PSORIASIS REFERRAL FORM

TEL 813.880.2500
FAX 813.880.2501
TOLL FREE 1.866.880.2507

Name:_____ Address:_____ _____ _____ Phone:_____

SSN:_____ DOB:_____ Sex:_____

Weight:_____ Height:_____ Allergies:_____ Ship to: ☐ Patient ☐ Clinic

Prescription Card: _____ Name of Insurer:_____ ID#_____ BIN:_____ PCN:_____

Group:_____ (please attach copies of insurance cards)

☐ L40.0 Psoriasis ☐ L40.5 Psoriatic Arthritis ☐ L40.59 Psoriasis Arthropathy ☐ L40.9 Psoriasis, Unspecified ☐ L73.2 Hidradenitis Suppurativa

ICD-10:_____ Diagnosis:_____ Has TB test been done? ☐Yes ☐No Date: _____

Test Result:_____ Does the patient have an active infection? ☐Yes ☐No

HBV ? ☐Yes ☐No if yes, is pt being treated? ☐Yes ☐No BSA% affected _____ Location of Psoriasis _____

Prior Failed Therapy? _____ Start Date: _____ End Date: _____

Reason for DC: _____ Current Medications:_____

Medication	Dose	Directions	Quantity	Refill
☐ Cimzia (Certolizumab)	☐ 200 mg/ml PFS	☐ **Initial:** inject 400 mg SC at 0, 2 and 4 weeks	☐ 6 x 200 mg/ml	0
	☐ 200 mg vials	**Maintenance:** ☐ Inject 200 mg SC every 2 weeks ☐ Inject 400 mg SC every 4 weeks ☐ Other _____	☐ 2 x 200 mg/ml	_____
☐ Enbrel (Etanercept)	☐ 50 mg/ml auto-injector	☐ **Initial:** inject 50 mg SC twice wkly for 3 months	☐ 8 x 50 mg/ml	2
	☐ 50 mg/ml PFS	**Maintenance:** ☐ Inject 50 mg SC once weekly	☐ 4 x 50 mg/ml	_____
☐ Humira (Adalimumab)	☐ 40 mg/0.8ml pens ☐ 40 mg/0.8ml PFS	**Plaque Psoriasis:** ☐ Initial: 80 mg SC as a single dose	☐ 2 x 40 mg/0.8ml	0
		Maintenance: ☐ 40 mg SC every other week Beginning one week after initial dose	☐ 2 x 40 mg/0.8ml	_____
		Psoriatic Arthritis: ☐ Inject 40 mg SC every other week	☐ 2 x 40 mg/0.8ml	_____
		Hidradenitis Suppurativa: ☐ Initial: 160 mg SC on day then 80 mg 2 weeks later	☐ 6 x 40 mg/0.8ml	0
		Maintenance: ☐ 40 mg SC every week, starting on day 29	☐ 4 x 40 mg/0.8ml	
		☐ Other		_____
☐ Otezla (Apremilast)	☐ Starter pack	☐ Follow package insert directions	☐ 1 pack (55 tablets)	0
	☐ 30 mg tab	Maintenance: ☐ Take 30 mg by mouth twice daily ☐ Other: _____	☐ 60 tablets	_____
☐ Simponi (Golimumab)	☐ 50 mg/0.5ml autoinjector ☐ 50 mg/0.5ml PFS	☐ Inject 50 mg SC once a month	☐ 1 x 50 mg/0.5ml	_____
☐ Stelara (Ustekinumab)	☐ 45 mg/0.5ml PFS ☐ 90 mg/ml PFS	☐ Initial: inject 45 mg SC at weeks 0 and 4 ☐ Or inject 90 mg SC at weeks 0 and 4	☐ 2 x 45 mg/0.5ml ☐ 2 x 90 mg/ml	0 _____
	Dosing: ☐ ≤100Kg: 45mg ☐ >100Kg: 90mg	Maintenance: ☐ Inject 45 mg SC every 12 weeks ☐ Inject 90 g SC every 12 weeks	☐ 1 x 45 mg/0.5ml ☐ 1 x 90 mg/ml	_____ _____
☐ Other	_____	_____	_____	_____

PRESCRIBER INFORMATION

Physicain Name:_____ Address:_____

State License#:_____ NPI:_____ DEA:_____

Phone #:_____ Fax #:_____ Office Contact Name /Number:_____

Prescriber's Signature:_____ Date:_____

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.