OTEZLA REFERRAL FORM

MED CENTER Rx
SPECIALTY PHARMACY
Dedicated to Improving Our Patients' Health
Part of The Elwyn Pharmacy Group

3100 MacCorkle Avenue S.E. | Suite 100
Charleston, WV 25304
TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

☐ **CURRENT PATIENT**
☐ **NEW PATIENT**

Feb 2017

Patient Name First Name Middle Name Last Name DOB _____ Emergency Phone _____
Street Address _____ Apt # _____ City _____ State ____ Zip _____
Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____
Diagnosis: ☐ L40.50 (Arthropathic psoriasis, unspecified) ☐ L40.0 (Psoriasis vulgaris) %BSA Affected _____
☐ L40.51 (Distal interphalangeal psoriatic arthropathy) ☐ L40.8 (Other psoriasis) %BSA Affected _____
☐ L40.52 (Psoriatic arthritis mutilans) ☐ L40.9 (Psoriasis, unspecified) %BSA Affected _____
☐ L40.53 (Psoriatic spondylitis) ☐ L40.59 (Other psoriatic arthropathy)
Affected Area(s) (Psoriasis only): ☐ Hands ☐ Arms ☐ Nails ☐ Trunk ☐ Feet ☐ Legs ☐ Scalp ☐ Groin ☐ Other _____

PREVIOUS/CURRENT TREATMENTS

Medication	Duration/Reason for D/C	Medication	Duration/Reason for D/C
☐ Methotrexate	_____	☐ Biologics _____	_____
☐ Cyclosporine	_____	☐ Topicals _____	_____
☐ Sulfasalazine	_____	☐ Other _____	_____
☐ Acitretin	_____	☐ PUVA / UV	_____

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# _____

Prescriber's Name / Practice _____ Nurse _____
Address _____ Suite# _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ DEA# _____

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

OTEZLA®

Starter Pack (Titration) Rx:
☐ 4-WEEK STARTER PACK (28 days) QTY: 55 tablets Refills: 0 **OR**
☐ PRESCRIBER PROVIDED PATIENT WITH 2-WEEK STARTER PACK SAMPLE (14 days)
QTY: 27 tablets Refills: 0 Date provided ____ / ____ / ____
Additional information _____
*Titration Starter Pack Rx is only for patients who did not receive a titration sample during their office visit. Elwyn Specialty Care will notify the patient via telephone prior to each shipment.

Maintenance Rx: 30 mg of Otezla
☐ x30 days ☐ x90 days
☐ TWICE DAILY (Recommended daily dose) **OR** ☐ ONCE DAILY (For patients with severe renal impairment)
Refills: ☐ 11 **OR** Other:_____ Special instructions _____

Bridge Rx: 30 mg of Otezla†
☐ TWICE DAILY (Recommended daily dose) (14 days) QTY: 28 tablets Refills: 12 **OR**
☐ ONCE DAILY (For patients with severe renal impairment) (28 days) QTY: 28 tablets Refills: 6

†Bridge Rx is at no cost, for eligible commercially insured, on-label diagnosed patients only, and not contingent on purchase requirements of any kind. Bridge Rx is not available to enrollees in Medicare, Medicaid, and other federal and state programs, as well as Massachusetts residents. Intended to support continuation of prescribed therapy if there is a delay in determining whether commercial prescription coverage is available.

Additional Notes: _____

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy 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**_____

Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit **www.MEDCENTERSPECIALTYPHARMACY.com** for online fillable forms.