

Today's Date _____

CURRENT PATIENT
 NEW PATIENT

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

<u>Medication</u>	<u>Duration/Reason for D/C</u>	<u>Medication</u>	<u>Duration/Reason for D/C</u>
<input type="checkbox"/> Methotrexate	_____	<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> Cyclosporine	_____	<input type="checkbox"/> Topicals	_____
<input type="checkbox"/> Sulfasalazine	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Acitretin	_____	<input type="checkbox"/> 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** _____

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