

Feb 2018

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

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*
 Take 30 mg once daily QTY: 55 Refills: _____
 Take 30 mg twice daily QTY: 30 Refills: _____
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 _____ Qty _____ Refills _____

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** _____

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 **Med Center Specialty Pharmacy at 304-344-0655** Visit **www.MEDCENTERSPECIALTYPHARMACY.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 (304) 344-0655

Toll Free: 1-855-633-5633 Direct Phone: (304) 344-8021

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