PSORIASIS REFERRAL FORM

565 Bound Brook Road | Middlesex, NJ 08846
TEL: 732-968-0414 | FAX: 732-424-1988

FREE DELIVERY & SHIPPING TO HOME OR DOCTORS OFFICE

Today's Date

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

Patient Name ____________ DOB ________ Weight ________ ☐ Male ☐ Female

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 ☐ Boro Hall Pharmacy Specialty Pharmacy

Diagnosis: ☐ L40.8 Psoriasis ☐ L40.59 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa Location: ☐ Scalp ☐ Groin ☐ Nails Other ________ Allergies ________

Severity ☐ Mild (<3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (>10% BSA) Patient currently on therapy? ☐ Yes ☐ No PPD Test ☐ Yes ☐ No Results ________

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 ____________ Office Contact ________

Street Address ____________ Suite # ________ City ________ State ________ Zip ________

Tel ________ Fax ________ Email ________

License# ________ NPI# ________ UPIN# ________ DEA# ________

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: ______

STELARA Starting Dose: ☐ 45 mg ☐ 90mg SQ initially & 4 weeks later
Maintenance Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks

OTEZLA® ☐ Titration Starter Pack SIG: Take as directed QTY 55 for 28 days
☐ Maintenance: 30mg SIG: Take 30mg twice a day QTY 60 Refills ______

COSENTYX
Starting Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ once weekly for 5 wks **Each 300 mg dose is given as 2 SQ injections of 150 mg**
QTY: 10 injection devices Refills: 0
Maintenance Supply ☐ Sensoready® Pen ☐ Prefilled Syringe
Once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ 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: ______

SIMPONI® (*Only for PsA)
☐ **50mg/0.5ml SmartJect™ (Autoinjector)** Inject 1 single-use Autoinjector SC once monthly QTY # 1
☐ **50mg/0.5mL PFS** Inject 1 single-use Prefilled Syringe SC once monthly QTY # 1

ENBREL 50 mg/ml not to be used in pediatric weighing less than 63 kg (138lbs)
☐ 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 (Max 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 Multiple-Use ☐ Vial 25 mg SQ BIW (72-96 hrs apart)
☐ 25 mg/0.5 ml PFS (Prefilled Syringes) QTY 8 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 four 40 mg pens/syringes SQ on day 1 OR inject two 40mg pen/syringes daily for 2 days, THEN two 40mg pens/syringes on day 15 QTY 6 NO REFILLS
Maint. Dose: ☐ 40 mg SQ every wk, beginning day 29 QTY ______ Refills ______

DUPIXENT® ☐ 300 mg/2 mL solution in a single-dose PFS
☐ Initial dose of 600 mg (two 300 mg injections in different injection sites),
QTY: ______ Refill: ______

Prescriber's Signature (signature required. NO STAMPS) ____________ **Date** ________

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Please fax completed form to **Boro Hall Pharmacy** at **732-424-1988**

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