BIOMATRIX SpRx

PSORIASIS REFERRAL FORM

TODAY'S DATE ________________

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

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

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	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ ______ #______	☐ ______ #______	☐ ______ #______
☐ ______ #______	☐ ______ #______	☐ ______ #______
☐ ______ #______	☐ ______ #______	☐ ______ #______

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: ☐ L40.0 Plaque Psoriasis ☐ L40.59 Psoriatic Arthritis ☐ L40.8 Psoriasis ☐ L73.2 Hidradenitis Suppurativa ☐ L40.50 Arthropathic Psoriasis
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______
☐ To my knowledge, patient has not previously been treated with a biologic/systemic agent for the diagnosed condition. If previously treatec
Is there a contraindication/intolerance/allergy to Cosentyx, Enbrel, Humira, Otezla, Remicade, Stelara, other biologic/systemic treatment?
☐ Methotrexate ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other ______ ☐ No
Is there documented failure of adequate trial on any of these medications?
☐ Methotrexate ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other ______ ☐ No

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 subcutaneous injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg subcutaneous injection given every 8 weeks thereafter

STELARA
Starting Dose: ☐ 45 mg ☐ 90 mg subcutaneously initially and 4 weeks later QTY: 2
Maintenance Dose: ☐ 45 mg ☐ 90 mg subcutaneously every 12 weeks
QTY: ____ Refills: ____

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

DUPIXENT® **Prefilled Syringe 300mg/2mL** QTY: ______ Refills: ______
☐ **Starting Dose:** 600 mg (two 300 mg injections in different injection sites)
☐ **Maintenance Dose:** 300 mg given every other week

ENBREL 50 mg/ml *not to be used in pediatric weighing less than 63 kg (138 lbs)*
☐ SureClick (prefilled autoinjector) ☐ Enbrel Mini™/AutoTouch ☐ Prefilled Syringe
Starting Dose: ☐ 50 mg subcutaneous 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 subcutaneously 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 subcutaneously BIW *(72-96 hours apart)* QTY: 8 Refills: ______

SIMPONI Dose: SmartJect™ ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL
SIG: ☐ inject 50mg subcutaneously monthly QTY: ______ Refills: ______

OTHER ______ Sig______ QTY: ______ Refills: ______

SILIQ **Prefilled Syringe 210mg/1.5 mL**
☐ **Starting Dose:** Inject 210 mg subcutaneously at weeks 0, 1 & 2 then maintenance QTY: 3
☐ **Maint. Dose:** Inject 210 mg subcutaneously every 2 wks QTY: ______ Refills: ______

☐ **HUMIRA** ☐ **HUMIRA Citrate-Free** *PSORIASIS*
☐ 40mg/0.8mL ☐ 80mg/0.8mL | ☐ PFS ☐ Pens
Starting Dose: ☐ Inject 80 mg subcutaneously on day 1, then 40 mg on day 8, then every other week QTY: 4 NO REFILLS
Maintenance Dose: ☐ 40 mg subcutaneously every other week QTY: 2 Refills: ______

☐ **HUMIRA** ☐ **HUMIRA Citrate-Free** *HIDRADENITIS SUPPURATIVA*
☐ 40mg/0.8mL ☐ 80mg/0.8mL | ☐ PFS ☐ Pens
Start Dose: ☐ Inject 160 mg on day 1, then inject 80 mg on day 15 QTY: ______ Refills: ______
Maintenance Dose: ☐ Inject 40 mg subcutaneously every week QTY: ______ Refills: ______

OTEZLA® ☐ 28 day Titration Starter Pack ☐ Tablets
☐ Take as directed **Can only be selected for the Titration Starter Pack** QTY: 55 Refills: ______
☐ Take 30 mg once daily QTY: 30 Refills: ______
☐ Take 30 mg twice daily QTY: 60 Refills: ______

CIMZIA
Starter dose: ☐ 400 mg subcutaneously initially and at weeks 2 and 4
Maintenance dose: ☐ 200 mg subcutaneously every two weeks OR ☐ 400 mg subcutaneously every 4 weeks
Plaque Psoriasis: ☐ 400 mg subcutaneously every other week.
For patients with weight ≤ 90 kg: a dose of 400 mg subcutaneously initially and at Weeks 2 and 4, followed by 200 mg subcutaneously every other week

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 wks thereafter QTY:______ Refills:______

TALTZ 80mg/mL *PSORIASIS* ☐ Autoinjector ☐ Prefilled Syringe
Starting Dose: ☐ Inject 160mg subcutaneously on Day 1 QTY: 2 pens Refills: 0
Induction Dose: ☐ Inject 80 mg subcutaneously starting week 2 and every 2 weeks through week 12 QTY: 6 pens Refills: 0
Maintenance Dose: ☐ Inject 80mg subcutaneously every 4 weeks
QTY: 1 pen Refills:____

TALTZ 80mg/mL *PSORIATIC ARTHRITIS* ☐ Autoinjector ☐ Prefilled Syringe
Starting Dose: ☐ Inject 160 mg subcutaneously at week 0 QTY: 2 Refills: 0
Maintenance: ☐ Inject 80 mg subcutaneously every 4 weeks QTY:____ Refills:____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)______ *Dispense as written* **Date**______
Prescriber's Signature (signature required. NO STAMPS)______ *Product Substition Permitted* **Date**______

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