GLEN ROCK MEDICAL PHARMACY
A BIOMATRIX Company

PSORIASIS REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452
TEL: 201-444-3200 | FAX: 201-444-5792
Toll Free: 866-888-3200

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

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

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

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: _____
☐ Initial dose of 100 mg SQ injection at week 0 and week 4
☐ Maint 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**
☐ Initial dose of 600 mg (two 300 mg injections in different injection sites)
☐ Maint Dose: 300 mg given every other week
QTY: _____ Refills: _____

STELARA **Start Dose:** ☐ 45 mg ☐ 90mg SQ initially & 4 wks later QTY: 2
Maint. Dose: ☐ 45 mg ☐ 90mg SQ every 12 wks 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 ____

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 wk QTY:4 NO REFILLS
Maint. Dose: ☐ 40 mg SQ every other week QTY: 2 Refills ____

HUMIRA *HIDRADENITIS SUPPURATIVA*
Initial Dose: ☐ Inject 160mg (4 pens) on day 1, then inject 80mg (2 pens) on day 15 QTY: _____ Refills: _____
Maint. 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*
QTY: 55 Refills _____
☐ Take 30 mg once daily QTY: 30 Refills _____
☐ Take 30 mg twice daily 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 _____

SIMPONI
Dose: SmartJect™ ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL
SIG: ☐ inject 50mg SQ monthly ☐ 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 Start 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 _____
Sig _____ Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Glen Rock Medical 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 **Glen Rock Medical Pharmacy** at **201-444-5792** Visit **www.GLENROCKMEDICALPHARMACY.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 (201) 444-5792

Toll Free: 1-866-888-3200 Direct Phone: (201) 444-3200

GlenRockMedicalPharmacy.com

GLEN ROCK MEDICAL PHARMACY
A BIOMATRIX Company

urac ACCREDITED SPECIALTY PHARMACY