Dermatology Prescription Referral Form

Carepoint Pharmacy
Phone: 732-885-1000 **Fax: 732-980-0357**
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Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name :	*Middle Initial :*	*Last Name :*	
Date of Birth :	*Gender:* ◯ M ◯ F	*SSN :*	
Street Address :	*City :*	*State :*	*Zip Code :*
Home Phone :	*Work Phone :*	*Cell Phone :*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name - Primary :	*Name of Insured :*		*Relationship :*
ID# :	*Group # :*		*Insurance Phone :*
Rx Carrier Name - Secondary :	*Rx ID# :*	*Rx Group #:*	*Rx Phone # :*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Cimzia *(200mg vials or Prefilled syringes)*	**Starting dose for Psoriatic arthritis : Prefilled syringe starter kit** ☐ 400mg SC at day 1 followed by 400mgSC at 2weeks then 4 weeks **Maintenance dosing:** ☐ 200mg SC every other week ☐ Prefilled syringes ☐ Pens ☐ 400 mg SC once every 4 weeks ☐ Prefilled syringes ☐ Pens		
Cosentyx *(150mg syringes)*	☐ **Starting Dose :** 300mg SC at 0,1, 2, 3 , 4 weeks **Maintenance dosing :** ☐ 300mg SC every 4 weeks ☐ Prefilled syringes ☐ Pens ☐ 150mg SC every 4 weeks ☐ Prefilled syringes ☐ Pens		
Erivedge *(150mg caps only)*	☐ _____ mg PO daily		
Enbrel	☐ 50 mg SC weekly ☐ 25 mg SC BIW ☐ Other: _____ ☐ PFS or ☐ Sureclick		
Otezla	☐ Therapy Initiation Titration Pack - Take as Directed ☐ 30mg twice a day ☐ 30mg once a day (Patients with Severe Renal Impairment)		
Stelara	**Starting Dose :** ☐ 45mg PFS SC x1 followed by 45mg PFS SC in 4 weeks (For patients weighting < 100kg) ☐ 90 mg PFS SC x1 followed by 90mg PFS SC in 4 weeks (For patients weighting > 100kg) **Maintenance dosing:** ☐ 45mg PFS SC ever y 12 weeks , ☐ 90mg PFS SC every 12 weeks		
Humira	☐ **Starting Dose Psoriasis:** 80mg SC x one initial dose then 40mg S C every other week starting one week after initial dose. Dispense in Psoriasis starter package for initial dosing. **Maintenance dosing:** ☐ 40mg SC every other week, ☐ Pen or ☐ PFS ☐ 40mg SC once a week, ☐ Pen or ☐ PFS		

Information Needed to Obtain Prior Authorizations

Primary Diagnosis: ☐ Psoriatic Arthropathy ICD-10 ☐ Other Psoriasis & similar disorders ICD-10 ☐ Other: _____

Weight :	*Allergies :*
Failed Therapies :	Please provide current list of medications :

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name :	*MD Last Name :*	*DEA # :*	
UPIN :	*State License # :*	*NPI :*	*Office E-mail :*
Office Address :		*City :* *State :*	*Zip Code :*
Office Phone:		*Office Fax :*	*Office Contact Name :*

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.*	*Date :*
Dr : Substitution Permitted	***Dr :*** No Substitution Permitted