PSORIASIS REFERRAL FORM

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Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name ____ Middle Name ____ Last 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 ☐ V-Care Pharmacy Date Needed____
Diagnosis ☐ L40.8 Psoriasis ☐ Other____ 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

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 (Prelled Syringes)
☐ 25 mg Multiple-Use ☐ Vial 25 mg SQ BIW *(72-96 hours apart)*
QTY 8 Refills ____

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

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion
Infusion supplies needed ☐ YES ☐ NO
Starting Dose:
☐ 5 mg/kg ____mg on week 0, week 2 & week 6 then,
Maintenance Dose:
☐ 5 mg/kg ____ mg every 8 weeks for ____ infusions every 8 weeks
Other ____ QTY ____ Refills ____

HUMIRA
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 ____

By signing this form and utilizing our services, you are authorizing V-Care 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**____

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Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.

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