V-CARE PHARMACY

PSORIASIS REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ D.O.B _____ Weight _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Daytime Telephone _____ Evening Telephone _____ 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) ☐ 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 subcutaneous weekly QTY: 4 Refills: _____

ENBREL 25 mg/mL *not to be used in pediatric weighing less than 63 kg (138 lbs)*
☐ 25 mg/0.5 mL PFS (Prefilled syringes) ☐ 25 mg Multiple-Use ☐ Vial 25 mg SQ BIW (72-96 hours apart)
SIG: _____ QTY: 8 Refills: _____

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: _____

HUMIRA PSORIASIS
Starting Dose: ☐ Inject two 40 mg pens/syringes SQ on day 1, then one 40 mg on day 8, then one 40 mg every other week QTY: 4 NO REFILLS
Maintenance Dose: ☐ 40 mg subcutaneously every other week QTY: 2 Refills: _____

HUMIRA HIDRADENITIS SUPPURATIVA
Starting Dose: ☐ Inject 160 mg (4 pens) on day 1, then inject 80 mg (2 pens) on day 15
QTY: _____ Refills: _____
Maintenance Dose: ☐ Inject 40 mg subcutaneously every week QTY: _____ Refills: _____

TREMFYA Prefilled Syringe 100 mg/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

SILIQ Prefilled Syringe 210 mg/1.5 mL
☐ **Starting Dose:** Inject 210 mg subcutaneously at weeks 0, 1 and 2 then maintenance QTY: 3
☐ **Maintenance Dose:** Inject 210 mg subcutaneously every 2 weeks QTY: _____ Refills: _____

TALTZ 80 mg/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 wk 2 & every 2 wks through wk 12 **QTY:** 6 pens **Refills:** 0
☐ **Maintenance Dose:** Inject 80mg subcutaneously every 4 weeks. **QTY:** 1 pen **Refills:** _____

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

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

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) _____ **Date** _____