Elwyn SPECIALTY CARE
Dedicated to Improving Our Patients' Health

PSORIASIS REFERRAL FORM

54 Conchester Road Glen Mills, PA 19342
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

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 ☐ Pharmacy Date Needed ______

Diagnosis ☐ 696.1 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 Elwyn Specialty 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 **Elwyn Specialty Pharmacy** at **610-545-6030** Visit us at **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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