PSORIASIS REFERRAL

Elizabeth Pharmacy
Everyone Deserves Good Health

1147 East Jersey St · Elizabeth, NJ 07201
Store: 908-994-1525 · **Fax:** 908-994-1508
Visit us at **Elizabethrx.com**

Rx: ☐ New ☐ Refill

PATIENT INFORMATION

Date: _____ Patient SS#: _____ **DIAGNOSIS DESCRIPTION:** _____ **ICD9 CODE**: _____

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City/Country: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Patient's Weight: _____ lbs. Date Recorded: _____ ☐ Male ☐ Female

Patient Allergies: _____

PRESCRIPTION INFORMATION

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 _____

REMICADE 100mg vial
☐ MD Office Infusion ☐ Home Infusion
Infusion supplies needed ☐ Yes ☐ No
Starting Dose: ☐ 5 mg/kg __mg on week 0, week 2 & week 6,
Maintenance Dose:
☐ 5mg/kg __mg every 8 weeks for __ infusions every 8 weeks

ENBREL 25 mg/ml not to be used in pediatric weighing less than 31 kg (68 lbs.)
☐ 25 mg/.6 ml PFS (Prelled Syringes)
☐ 25 mg Multiple-Use ☐Vial 25 mg SQ BIW (72-96 hours apart)
QTY 8 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 _____

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

SIMPONI® (*Only for PSA)
Starting Dose: ☐ 50mg/0.5ml SmartJect™ (Autoinjector)
Inject 1 single-use Autoinjector SC once monthly QTY # 1
Maintenance Dose: ☐ 50mg/0.5mL Prefilled Syringe
Inject 1 single-use Prefilled Syringe SC once monthly QTY # 1

INSURANCE INFORMATION

Insured's Name: _____ Relation to Patient: _____ Has Medicare: ☐Yes ☐ No If yes, Medicare #:_____

Prescription Card: ☐Yes ☐No If Yes, Carrier: _____ Tel: _____ Fax: _____

Policy/Group #: _____ Bin #: _____ ___ Pcn #: _____ RXID#: _____

RX Group #:_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____

Street Address: _____ Suite #: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____ Email: _____

License #: _____ NPI #: _____ UPIN #: _____

I authorize Elizabeth Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process

Physician Signature: _____ M.D. DEA #: _____