Prescriber Name: _____ License #: _____ DEA # _____

Address: _____

Phone: _____ Fax: _____ Contact: _____

Patient Name: _____ D.O.B.: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Insurance Information: _____

Date: _____ Needs by Date: _____ | Ship to ☐ Patient ☐ Office ☐ Nursing Training

INSURANCE INFORMATION

Primary Insurance/ Prescription Card:	PLEASE FAX COPY OF INS CARD (FRONT & BACK)	Secondary Insurance/ Prescription Card:	PLEASE FAX COPY OF INS CARD (FRONT & BACK)

CLINICAL INFORMATION:

(OPTIONAL - but will assist in insurance authorization and patient education)

Methotrexate contraindicated due to social activities ☐ Yes ☐ No

Methotrexate contraindicated because patient is of child bearing age ☐ Yes ☐ No

Diagnosis:

☐ L40.9 Psoriasis
☐ L40.59 Psoriatic Arthritis
☐ Other: _____

Other Clinical Info:

- Does patient have a latex allergy?
  ☐ Yes ☐ No
- TB/PPD Test Given?
  ☐ Yes ☐ No
  _____% BSA (body surface) area) affected by Psoriasis
- Weight: _____ Kg or ____ lb
- Other Comments:

_____
_____
_____
_____
_____
_____

Prior (FAILED) Medications: | Clinical Information (if applicable):

	Medication	*Strength*	*Duration of Treatment/Reason for Discontinuation*
Biologics	☐ Adalimumab	_____	_____
	☐ Alefacept	_____	_____
	☐ Etananercept	_____	_____
	☐ Efalizumab	_____	_____
Oral Meds	☐ Acitretin	_____	_____
	☐ Corticosteroids (oral)	_____	_____
	☐ Cyclosporine	_____	_____
	☐ Methotrexate	_____	_____
	☐ NSAID	_____	_____
	☐ Sulfasalazine	_____	_____
Topical Meds	☐ Calcipotriene	_____	_____
	☐ Cyclosporine	_____	_____
	☐ Tazarotene	_____	_____
Phototherapy	☐ PUVA	_____	_____
	☐ UVB	_____	_____
OTHER	☐	_____	_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Enbrel®	☐ 50mg/ml Sureclick Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 50mg SC ONCE a week ☐ Psoriasis Arthritis Dose: Inject 50mg SC ONCE a week ☐ Other: _____		
☐ Humira®	☐ Psoriasis Starter Package ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Psoriasis Induction Dose: Inject two 40mg pens/syringes SC on day 1, then one 40mg pen/syringe on day 8, then one 40mg pen every other week thereafter ☐ Psoriasis Maintenance Dose: Inject one 40mg pen/syringe SC every other week ☐ Psoriatic Arthritis Dose: Inject one 40mg pen/syringe SC every other week ☐ Other: _____		
☐ Remicade®	100mg Vial	☐ Induction Dose: Infuse 5mg/kg in 250mL of 0.9% NaCl at week 0, week 2, week 6, and every 8 weeks thereafter ☐ Maintenance Dose: Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 weeks ☐ Other: _____		
☐ Simponi	☐ 50mg/0.5ml SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Psoriasis Arthritis Dose: Inject 50 mg (0.5ml) subcutaneously once a month ☐ Other: _____		
☐ Stelara	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/1ml Prefilled Syringe.	☐ For patients weighing <100kg (220lbs) Inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks. ☐ For patients weighing > 100kg (220lbs): Inject 90mg SC initially and 4 weeks later, folowed by 90 mg every 12 weeks,		
☐ Otezla	☐ 4 Week starter pack ☐ 30 mg tablet	☐ Follow package directions for 4 week titration ☐ Maintenance dose: 30mg by mouth twice a day		

_____ _____

(Prescriber Signature) (Date)

Enexia Specialty

Dermatology Referral Form

FAX REFERRAL TO: 718-360-9655 or call 718-556-0942