ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

PSORIASIS REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

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 ☐ 696.0 Psoriatic Arthritis 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

☐ **OTEZLA**
Directions: Day 1: 10 mg in AM
Day 2: 10 mg in AM; 10 mg in PM
Day 3: 10 mg in AM; 20 mg in PM
Day 4: 20 mg in AM; 20 mg in PM
Day 5: 20 mg in AM; 30 mg in PM
Day 6,thereafter: 30 mg twice daily
QTY _____ Refills_____

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 Multiple-Use ☐ Vial 25 mg SQ BIW *(72-96 hrs apart)*
☐ 25 mg/0.5 ml PFS (Prefilled Syringes) QTY 8 Refills _____

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 wks for ____ infusions every 8 wks
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 _____

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

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

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____