aleracare
advanced specialty pharmacy

Psoriasis
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Consideration

Diagnosis (ICD 10): ◯ L40 Psoriasis ◯ L40.52 Psoriatic Arthritis

History: ◯ Other (please specify): _____

Medication	Strength/Directions for Use		Refills
◯ **ENBREL®**	◯ 50mg/ml Auto injector ◯ 50mg/ml pre-filled syringe	◯ Induction: Inject 50mg SC TWICE a week (72- 96 hours apart) x 3 months ◯ Inject 50mg SC once a week	
◯ **HUMIRA®**	◯ 40mg/0.8ml Pen	◯ Start: 80mg day 1, then 40mg one week later, then 40mg every other week thereafter	
◯ **OTEZLA®**	◯ Starter (Titration) Pak - take as directed x 14 ◯ Maintenance Dose -30mg twice daily by mouth		
◯ **OTREXUP**	◯ 10mg/0.4ml ◯ 15mg/0.4ml ◯ 20mg/0.4ml ◯ 20mg/0.4ml ◯ 25mg/0.4ml	◯ Inject SC weekly (Info: use lowest effective dose; give w/folic acid 1mg q doe leucovorin 5mg qwk; consider lower doses in elderly pts	
◯ **STELARA®**	◯ 45mg/0.5 ml pre-filled syringe ◯ 90 mg/ml pre-filled syringe	◯ Initiation: inject the contents of 1 pre-filled syringe SC on day 1 ◯ Maintenance: inject the contents of 1 pre- filled syringe SC starting day 29 & every 12 weeks thereafter	
◯ **TACLONEX®**	◯ 60mg topical suspension ◯ 120 gm topical suspension	◯ Apply to affected areas once daily for up to 8 weeks	

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____