Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare Psoriasis Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient 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 ☐ L40.59 Psoriatic Arthritis ☐ L40.8 Psoriasis ☐ L73.2 Hidradenitis Suppurativa ☐ 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 Multiple-Use ☐ Vial 25 mg SQ BIW *(72-96 hrs apart)*
☐ 25 mg/0.5 ml PFS (Prefilled Syringes) QTY 8 Refills ____

STELARA ***must be delivered to physician's office***
Starting Dose: ☐ 45 mg ☐ 90mg SQ initially & 4 weeks later
Maintenance Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks

OTEZLA® ☐ Titration Starter Pack ☐ Tablets
Dose:
☐ Take as directed *These directions can only be selected for the Titration Starter Pack* Qty 27 Refills ____
☐ Take 30 mg once daily Qty 30 Refills ____
☐ Take 30 mg twice daily Qty 60 Refills ____

OTHER _____
Sig _____ Qty _____ Refills _____

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion
Infusion supplies needed ☐ ☐ NO
Starting Dose: ☐ 5 mg/kg ____mg on week 0, week 2 & week 6 then,
Maint. Dose: ☐ 5 mg/kg _____ mg every 8 wks for ____ infusions every 8 wks
Other _____ QTY _____ Refills _____

HUMIRA ☐ 40 mg Autoinjector ☐ 40 mg PFS
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
Maint. Dose: ☐ 40 mg SQ every other week QTY 2 Refills ____
Hidradenitis Suppurativa
Starting Dose: ☐ Inject four 40 mg pens/syringes SQ on day 1 OR inject two 40 mg pen/syringes daily for 2 days, THEN two 40mg pens/syringes on day 15, QTY 6 NO REFILLS
Maint. Dose: ☐ 40 mg SQ every wk, beginning day 29 QTY ___ Refills ____

COSENTYX ☐ Sensoready® Pen ☐ Prefilled Syringe
Starting Dose *Weeks 0, 1, 2, 3, and 4, then once every 4 weeks*
SIG: ☐ Inject 300 mg dose SQ once weekly for 5 wks ***Each 300 mg dose is given as 2 SQ injections of 150 mg***
QTY: 10 injection devices Refills: 0
Maintenance Supply *Once every 4 weeks*
SIG: ☐ Inject 300 mg dose SQ once every 4 weeks ***Each 300 mg dose is given as 2 SQ injections of 150 mg***
☐ Other: _____
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing Padek Healthcare 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** _____

PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127