IRVINGTON PHARMACY

PSORIASIS REFERRAL FORM

1070 Springfield Ave, Irvington, NJ 07111
Phone : 862-255-2804 | Fax : 860-229-2417
E-mail : irvingtonpharmacy@gmail.com

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 ☐ 696.1 Psoriasis ☐ 696.0 Psoriatic Arthritis Other Location ☐ Scalp ☐ Groin ☐ Nails Other Allergies

Severity ☐ Mild (<3% BSA) ☐ Moderate (>10% BSA) ☐ Severe (3-10% 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 BIW87 (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/0.5 ml PFS (Prefilled Syringes)

☐ 25 mg Multiple-Use ☐ Vial 25 mg SQ BIW (72-96 hours apart)

QTY 8 Refills__________

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

Maintenance Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks

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:

☐ mg/kg________mg every 8 weeks for______infusions every 8 weeks

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 Prefilled Syringe**

Inject 1 single-use Prefilled Syringe SC once monthly QTY # 1

Prescriber's Signature signature required. NO STAMPS) Date

IMPORTANT NOTICE::This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: Riverfront Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.