@pfsprx #pfsprx

VERBAL ORDER FORM
DERMATOLOGY

398 W. Grand Avenue | Rahway, NJ 07065
Ph 844-527-9486 | Fx 866-285-7628
NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPrx.com

Today's Date ____________
Date Needed ____________

Specialty Pharmacy Expires 07/01/2023

Rare Disease Pharmacy Center of Excellence Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

Patient Name____________ Date of Birth____________ ☐ Male ☐ Female
Address____________ Apt #_____ City____________ State_____ Zip_____
Telephone____________ Cell____________ SSN____________ Email____________
Allergies____________ Comorbidities____________

Primary Insurance____________ ID#____________ Group #____________
Insured's Name____________ Employer____________
City____________ State________ Phone____________

ICD-10 Diagnosis Code: ☐ L40.59 Psoriatic Arthritis ☐ L40.0 Psoriasis ☐ L20.____ Atopic Dermatitis ☐ M35.2 Behçet's Disease ☐ Other____________
PPD (TB Test) ☐ Yes ☐ No Date____________ Does patient have latex allergy (for Enbrel)? ☐ Yes ☐ No
__________% BSA (body surface area) affected by Psoriasis Weight ___________ lb or ___________Kg
Methotrexate contraindicated: Due to social activities? ☐ Yes ☐ No Because patient is of child bearing age? ☐ Yes ☐ No
Previously treated for this condition? ☐ Yes ☐ No Please indicate failed medication(s) below

	Medication	Strength	Duration of Treatment/ Reason for Discontinuation		Medication	Strength	Duration of Treatment/ Reason for Discontinuation
Biologics				Oral Meds			
Topical Meds				Phototherapy			

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

SKYRIZI ☐ 75 mg/0.83 mL PFS *PLAQUE PSORIASIS*
☐ **Start Dose:** Inject 150mg (two 75 mg injections) subcutaneously at week 0, week 4 QTY: 4 Refills: 0
☐ **Maintenance Dose:** Inject 150mg (two 75 mg injections) subcutaneously every 12 weeks thereafter QTY: _____ Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Skyrizi Complete*

DUPIXENT ☐ 300mg/mL PFS ☐ 300mg/mL Pen Injector ☐ 200mg/1.14mL PFS *ATOPIC DERMATITIS*
Adolescents ☐ (< 60kg) **Starter:** Inject 400mg SQ on Day 1, then inject 200mg SQ every other week. QTY: 4 PFS Refills: 0
Maintenance: Inject 200mg SQ every other week. QTY: 2 PFS Refills: _____
☐ (≥ 60kg) **Starter:** Inject 600mg SQ on Day 1, then inject 300mg SQ every other week. QTY: 4 PFS Refills: 0
Maintenance: Inject 300mg SQ every other week. QTY: 2 PFS Refills: _____
Adults ☐ **Starter:** Inject 600mg SQ on Day 1, then inject 300mg SQ every other week. QTY: 4 PFS Refills: 0
Maintenance: Inject 300mg SQ every other week. QTY: 2 PFS Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *MyWay™*

ILUMYA™ ☐ Prefilled Syringe 100mg/mL
☐ **Starting Dose:** Initial dose of 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 12 weeks thereafter. QTY: _____ Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *ILUMYA SUPPORT™*

COSENTYX® ☐ 150 mg Sensoready® Pen ☐ 150 mg 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 weeks *(Each 300 mg dose is given as 2 SQ injections of 150 mg)* QTY: 10 injection devices Refills: 0
☐ Inject 150 mg dose once weekly for 5 weeks QTY: 5 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)*
☐ Inject 150 mg dose SQ once every 4 weeks
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Cosentyx® Connect*

HUMIRA® and HUMIRA Citrate-Free® *Patient weight (kg)*_____
Adult Psoriasis/Adolescent HS (30kg to <60kg) Starter:
☐ 80mg/0.8ml + 40mg/0.4ml citrate-free Pen Starter Kit (3-ct)
☐ 40mg/0.8ml Pen Original Starter Kit (4-ct)
SIG: Inject 80mg SQ on Day 1, then inject 40mg SQ on Day 8, then inject 40mg SQ every other week. QTY: 1 Kit Refills: 0
Adult HS Starter: ☐ 80mg/0.8ml citrate-free Pen Hidradenitis Suppurativa Starter Kit (3-ct)
☐ 40mg/0.8ml Pen Hidradenitis Suppurativa Starter Kit (6-ct)
SIG: Inject 160mg SQ on Day 1, then inject 80mg SQ on Day 15. QTY: 1 Kit Refills: 0
Maintenance: ☐ 40mg/0.4ml citrate-free Pen (2-ct) ☐ 40mg/0.4ml citrate-free PFS (2-ct)
☐ 40mg/0.8ml Pen (2-ct) ☐ 40mg/0.8ml PFS (2-ct)
☐ **Adult Psoriasis/Adolescent HS Sig:** Inject 40mg SQ every other week.
☐ **Adult Hidradenitis Suppurativa Sig:** Inject 40mg SQ every week starting on Day 29.
☐ **Other:** ____________
QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Ambassador Program*

CIMZIA® 200mg/mL ☐ PFS 2-ct ☐ PFS 6-ct Starter Kit
Psoriasis ☐ Standard Dose: Inject 400mg SQ every other week QTY: 2 PFS Refills: _____
Less than 90kg, may consider: ☐ Starter: Inject 400mg SQ at weeks 0, 2, and 4 QTY: 6 PFS Refills: 0
☐ Maintenance: Inject 200mg SQ every other week thereafter QTY: 2 Refills: _____
Psoriatic Arthritis ☐ Starter: Inject 400mg SQ at week 0, 2, and 4 QTY: 6 PFS Refills: 0
☐ Maintenance: Inject 200mg SQ every other week QTY: 2 Refills: _____
☐ Maintenance: Inject 400mg SQ every four weeks QTY: 2 Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *CIMplicity*

TREMFYA™ ☐ Prefilled Syringe 100mg/mL ☐ One-Press Injector 100mg/mL
☐ **Starting Dose:** Initial dose of 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 8 weeks thereafter. QTY: _____ Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Janssen CarePath*

SILIQ™ ☐ 210 mg/1.5 mL PFS
☐ Induction Dose: Inject 210 mg of SILIQ at Weeks 0, 1, and 2 then maint. QTY: 3 Refill: _____
☐ Maintenance Dose: Inject 210 mg of SILIQ every 2 weeks QTY: 2 Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Siliq Solutions™*

OTEZLA® ☐ Prescriber provided Two-Week Starter Pack on ____________
Starter: ☐ 28 Day Starter Pack SIG: Take as directed QTY: 55 Refill: 0
☐ 30mg twice daily (recommended) ☐ 30mg daily (for severe renal impairment)
Maintenance: ☐ SIG: Take one tablet by mouth twice daily QTY: 60 Refill: _____
☐ SIG: Take one tablet by mouth daily QTY: 30 Refill: _____
☐ If applicable, enroll in *Otezla SupportPlus™* ☐ If applicable, enroll in *Bridge RX Program*

TALTZ® 80mg ☐ Autoinjector ☐ Prefilled Syringe
Starting Dose: ☐ Inject 160mg SQ at wk 0 followed by 80mg at wks 2,4,6,8,10 & 12 QTY: 8 Refills: 0
Maintenance Dose: ☐ Inject 80mg SQ every 4 weeks QTY: _____ Refills: _____
☐ Other: ____________ QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Taltz Together™*

SIMPONI™ ☐ SmartJect™ Autoinjector ☐ PFS 50mg/0.5mL
☐ **Psoriatic Arthritis Dose:** Inject 50 mg (0.5ml) SQ once a month QTY: 1 vial Refills: _____
☐ Other: ____________ QTY: _____ Refills: _____

SIMPONI ARIA™ ☐ 50mg/4ml (12.5mg/ml) in a single use vial
☐ **Dose:** 2mg/kg intravenous infusion over 30 minutes at wks 0 & 4, then every 8 wks QTY: 1 vial Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *SimponiOne®*

RASUVO® ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg
☐ Inject _____mg subcutaneously weekly QTY: 4 Refill: _____
☐ If applicable, enroll patient in *CORE Connections*

ENBREL® (etanercept) ☐ SureClick™ Autoinjector 50mg ☐ Prefilled Syringe 50mg
☐ Enbrel Mini™/AutoTouch 50mg ☐ Multiuse Vial 25mg ☐ Prefilled Syringe 25mg/0.5ml
Dispense: ☐ **Psoriasis Induction Dose:** Inject 50mg SQ TWICE a week (3-4 days apart) for 3 months, then maintenance dosing QTY: 8 Refills: 2
☐ **Psoriasis Maintenance Dose:** Inject 50mg SQ ONCE a week QTY: _____ Refills: _____
☐ **Psoriatic Arthritis Dose:** Inject 50mg SQ ONCE a week QTY: _____ Refills: _____
☐ Other: ____________ QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *ENBREL Support™*

STELARA™ ☐ **45mg/0.5mL PFS** ☐ **90mg/mL PFS** *Patient Weight (kg):* _____
Starting Dose: ☐ Inject 45mg (1 PFS) SQ for patients weighing <100kg (220lbs) initially and then 4 weeks later QTY: 1 PFS Refills: 0
Maintenance Dose: ☐ Inject 45mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refills: _____
Starting Dose: ☐ Inject 90mg (1 PFS) SQ for patients weighing >100kg (220lbs) initially and then 4 weeks later QTY: 1 PFS Refills: 0
Maintenance Dose: ☐ Inject 90mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refills: _____
☐ Other: ____________ QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Janssen CarePath*

REMICADE® ☐ 100mg Vial QTY: _______# of vials Refill_____
☐ Induction Dose: Infuse 5mg/kg in 250mL of 0.9% NaCl at wk 0,wk 2, wk 6, & every 8 wks thereafter
☐ Maintenance Dose: Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 wks ☐ If applicable, enroll patient in *Janssen CarePath*
☐ Other: ____________

OTHER ____________ SIG ____________ QTY: _____ Refill: _____

Prescriber's Name / Practice ____________ Office Contact____________
Address____________ Suite#______ City____________ State_____ Zip_____
Tel____________ Fax____________ Email____________
License#____________ NPI#____________ UPIN#____________ DEA#____________
Prescriber's Signature (signature required. NO STAMPS)____________ **Date**____________

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