Carepoint™
A Pharmacy That Truly Cares

Psoriasis Referral Form

P: (855) 237-9112 | F: (855) 237-9113 | www.carepointrx.com

Thank You For Trusting Us With Your Patients Care.

PATIENT INFORMATION

Patient Name ________________________ DOB ______________ Phone ________________

Address ________________________ City, State ______________ Zip ____________

Weight: ________ Known Allergies: ________________________________

PLEASE FAX COPY OF FACE SHEET, IF AVAILABLE

MEDICAL ASSESSMENT

Diagnosis: ☐ 696.1 Psoriasis **Severity:** ☐ Severe ☐ Moderate ☐ Mild **Negative PPD Test?** ☐ Yes ☐ No

Body Coverage: ______% **History of Cancer?** ☐ Yes ☐ No **Secondary Infection?** ☐ Yes ☐ No

Prior Failed Treatments: ☐ Topical Medications ☐ Methotrexate ☐ PUVA/UVB ☐ ________________

Duration & Details: ________________________________

PRESCRIPTION INFORMATION

Drug	Strength	Directions	Days Supply / Refills
Cosentyx®:	☐ 150mg prefilled syringe	☐ Starter Dose: Inject ______mg SC at week 0, 1, 2, 3 and 4 ☐ Maintenance: Inject ______mg SC once every 4 weeks	_______ /______
Enbrel®:	☐ 25mg ☐ 50mg syringe	☐ Inject ______mg subcutaneously _____ times per week	_______ /______
Humira®:	☐ 40mg prefilled syringe	☐ Starter Dose: Inject 80mg subcutaneously on Day 1, then 40mg every other week, starting on Week 2 ☐ Maintenance: Inject 40mg subcutaneously every other week	_______ /______
Stelara®:	☐ 45mg syringe (< 220 lbs.) ☐ 90mg syringe (> 220 lbs.)	☐ Inject ______mg SC on day 0, week 4, then every 12 weeks	_______ /______
Remicade®:	☐ 100mg/20ml vial	☐ Starting Dose: Infuse ______mg IV on week 0, week 2 and week 6 ☐ Maintenance: Infuse ______mg IV every ______ weeks	_______ /______
Otezla®:	☐ 10mg ☐ 20mg ☐ 30mg capsule ☐ Take _____mg PO _____ x daily	☐ Day 1: 10mg PO in the morning; Day 2: 10mg in AM & 10mg in PM Day 3: 10mg in AM & 20mg in PM; Day 4: 20mg in AM & 20mg in PM Day 5: 20mg in AM & 30mg in PM; Day 6 and thereafter: 30mg BID	_______ /______
Soriataine®:	☐ 10mg ☐ 17.5mg ☐ 22.5mg ☐ 25mg capsule	☐ Take __________ once daily with food	_______ /______
OTHER:	☐ Drug: ________________	☐ Sig: ________________________	_______ /______
	☐ Drug: ________________	☐ Sig: ________________________	_______ /______

☒ Dispense sufficient quantity of all necessary supplies (syringes, needles, alcohol wipes, etc.) for medication administration

PLEASE FAX COPY OF FRONT AND BACK OF ALL INSURANCE CARDS

PRESCRIBING PHYSICIAN

Physician Name ________________________ Phone ______________ Fax ______________

Address ________________________________

________________________ NPI/DEA# ________________ Date ____________

Physician Signature

By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent when handling prior authorizations and other medical and prescription insurance forms and communications