Dermatology

Fax Referral to: 512-487-5033 Phone: 512-432-5190
Email Referral to: april@martinsspecialtypharmacy.com

Patient Information

Patient Name

Address

City, State, Zip

Primary Phone Emergency Contact Name & Phone Number

Date of Birth ☐ Male ☐ Female

Social Security #

Prescriber Information

Prescriber Name

DEA# NPI# License #

Address

City, State, Zip

Phone Fax

Contact Person

Insurance Information:

Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information:

Please fax recent clinical notes, labs and tests with this prescription to expedite the Prior Authorization

Diagnosis: ☐ L40.8 Psoriasis ☐ L40.59 Psoriatic Arthritis ☐ Other: ICD code ________ Condition: ________

% BSA: ________ ☐Hands ☐Soles ☐Head ☐Neck ☐Genitalia ☐Nails ☐Other: ________

Does the patient have a latex allergy? ☐Yes ☐No Allergies: ________

Prior Failed Therapy: ☐Cimzia ☐Enbrel ☐Humira ☐Orencia ☐Remicade ☐Rituxan ☐Simponi ☐Soriatane ☐Stelar

☐Cyclosporin ☐Methotrexate ☐PUVA / UVB ☐Topicals (list all tried): ________ ☐Other: ________

Length of Treatment: ________ Reason for Discontinuing: ________

TB/PPD Test Given? ☐Yes ☐No Date of Negative TB Test: ________ Hepatitis B Ruled Out? ☐Yes ☐No

If Hep B not ruled out, treatment started? ☐Yes ☐No Height: ________ Weight: ________

Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills
Cimzia® For psoriatic arthritis	Starter Dose: ☐ Starter Kit (200mg Prefilled Syringes)	☐ Inject 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200mg/ml PFS	0
	☐ 200mg/ml Prefilled Syringe	☐ Inject 400mg Sub-Q every 4 weeks ☐ Inject 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200mg/ml PFS	______
Enbrel®	☐ 50mg/ml Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe	☐ Induction Dose: Inject 50mg Sub-Q TWICE a week (72 - 96 hours apart) for 3 months	☐ 8 Syringes	2
		☐ Inject 50mg Sub-Q every week ☐ Inject 25mg Sub-Q twice a week	☐ 4 Syringes ☐ 8 Syringes	______
Humira®	☐ 40mg/0.8ml Prefilled Auto Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 80mg (2x40mg) Sub-Q on Day 1, 40mg on Day 8, then 40mg every other week	☐ 4 week supply	0
		☐ Inject 40mg Sub-Q EVERY OTHER week ☐ Inject 40mg Sub-Q ONCE a week	☐ 4 week supply	______
Simponi® For psoriatic arthritis	☐ 50mg/0.5ml SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg Sub-Q once every month ☐ Other Dose: ________	☐ 4 week supply	______
Stelara®	☐ 45mg/0.5ml Prefilled Syringe (for Patients < 220 lbs) ☐ 90mg/1ml Prefilled Syringe (for Patients > 220 lbs)	☐ Inject 45mg Sub-Q initally, the 4 weeks later, than every 12 weeks ☐ Inject 90mg Sub-Q initally, the 4 weeks later, than every 12 weeks	☐ 4 week supply	______
Targretin®	☐ 75mg Capsules		☐ 4 week supply	______
	☐ 1% Gel	Apply every other day for 1 week, increase to once daily for 1 week, twice daily for 1 week, 3 times daily for 1 week, finally 4 times daily	☐ 4 week supply	______
Valchlor®	☐ 0.016% Gel			______
Zolinza®	☐ 100mg Capsules	☐ 400mg (4 capsules) once a day ☐ Other: ________	☐ 120	______

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW ________ Date

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process

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