ACS Advanced Care Scripts

DermaCare™ Referral Form

Phone: 877-985-MEDS (6337) **Fax: 866-679-7131**

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name:	*Middle Initial:*	*Last Name:*	
Date of Birth:	*Gender:* ☐ M ☐ F	*SSN:*	
Street Address:	City:	State:	Zip Code:
Home Phone:	*Work Phone:*	*Cell Phone:*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name – Primary:	*Name of Insured:*		*Relationship:*
ID#:	*Group #:*		*Insurance Phone:*
Rx Carrier Name – Secondary:	*Rx ID#:*	*Rx Group #:*	*Rx Phone #:*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription			
Drug Name	**Form/Strength/Directions for Use**	**Qty**	**Refills**
Cimzia ***(200mg vials or Prefilled syringes)***	**Starting dose for Psoriatic arthritis: Prefilled syringe starter kit** ☐ 400mg SC at day 1 followed by 400mgSC at 2weeks then 4 weeks **Maintenance dosing:** ☐ 200mg SC every other week ☐Prefilled syringes ☐vials ☐ 400 mg SC once every 4 weeks ☐Prefilled syringes ☐vials		
Cosentyx ***(150mg syringes)***	☐ **Starting Dose:** 300mg SC at 0,1, 2, 3 , 4 weeks **Maintenance dosing:** ☐ 300mg SC every 4 weeks ☐Prefilled syringes ☐Pens ☐ 150mg SC every 4 weeks ☐Prefilled syringes ☐Pens		
Erivedge ***(150mg caps only)***	☐ _____mg PO daily		
Enbrel	☐ 50 mg SC weekly | ☐ 25 mg SC BIW| ☐ Other: ___ ☐ PFS or ☐ Sureclick		
Otezla	☐ Therapy Initiation Titration Pack-Take as Directed ☐ 30mg twice a day ☐ 30mg once a day (Patients with Severe Renal Impairment)		
Stelara	**Starting Dose:** ☐ 45mg PFS SC x1 followed by 45mg PFS SC in 4 weeks (For patients weighting ≤ 100kg) ☐ 90 mg PFS SC x1 followed by 90mg PFS SC in 4 weeks (For patients weighting > 100kg) **Maintenance dosing:** ☐ 45mg PFS SC every 12 weeks , ☐ 90mg PFS SC every 12 weeks		
Humira	☐ **Starting dose for Psoriasis:** 80mg SC x one initial dose then 40mg SC every other week starting one week after initial dose. Dispense in Psoriasis starter package for initial dosing. **Maintenance dosing:** ☐ 40mg SC every other week, ☐ Pen or ☐ PFS ☐ 40mg SC once a week, ☐ Pen or ☐ PFS		

Information Needed to Obtain Prior Authorizations	
Primary Diagnosis: ☐ Psoriatic Arthropathy ICD-10 | ☐Other Psoriasis & similar disorders ICD-10 | ☐ Other: ___	
Weight: pounds	*Allergies:* ___
Failed Therapies: ___	*Please provide current list of medications:* ___

Complete Prescriber Information in Section Below NOT Included on Attached Prescription				
MD First Name:		*MD Last Name:*		*DEA #:*
UPIN:	*State License #:*	*NPI:*	*Office E-mail:*	
Office Address:		City:	State:	Zip Code:
Office Phone:		*Office Fax:*	*Office Contact Name:*	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS	
☐ *I authorize Advanced Care Scripts to initiate a Prior Authorization on my behalf.*	**DATE** *TLC2/3/16*
Dr: ***Substitution Permitted***	**Dr:** ***No Substitution Permitted***