Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Dermatology (N-Z)

Referral for Medication and Patient Management Program

OptiMed

Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F
DOB _____ SSN _____
Phone _____ 2nd Phone _____
Address _____ Apt/Suite _____
City, State, ZIP _____
Primary language, if other than English _____

Provider Information

Prescriber _____
NPI _____ DEA _____
Practice Name _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Pharmacy to facilitate ☐ Not needed

Ship first fill to ☐ Prescriber's office ☐ Patient ☐ Other _____

Clinical Information

Diagnosis **Date of diagnosis** _____
☐ L20.9 Atopic dermatitis, unspecified
☐ L40.0 Psoriasis vulgaris
☐ L40.5 Psoriatic arthritis
☐ L40.8 Other psoriasis
☐ L40.9 Psoriasis, unspecified
☐ L73.2 Hidradenitis suppurativa
☐ Other (include ICD-10) _____

BSA affected(%) _____
List areas affected _____
_____
Prior treatments & reason for discontinuation _____
_____
_____
_____

Date of negative TB test _____
or Check here if ☐ TB test pending, will fax results
HBV negative or treated ☐ Yes ☐ No
Weight _____ ☐ lb ☐ kg **Height** _____ ☐ in
Allergies _____
_____
Other notes _____

AAD Consensus Statement on Psoriasis Therapies
☐ Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationship.
☐ Psoriasis is covering greater than 10% of BSA. ☐ Psoriasis is on palms, soles, head and neck, or genitalia. ☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints.

Medication	Directions	Quantity	Refills
☐ **Orencia®** 125mg (abatacept)	☐ Inject 125mg SQ once weekly.	4 pens/syringes	_____
☐ **Otezla®** 30mg (apremilast)	☐ **Titration Starter Pack:** Take as directed per package. -or- if 14-day starter pack **already given to patient, check here** ☐ Date provided _____ **Maintenance:** ☐ Take one tablet (30mg) PO twice daily. ☐ Take one tablet (30mg) PO once daily (severe renal impairment).	28-day starter pack N/A ☐ 60 tablets ☐ 30 tablets	Zero N/A _____
☐ **Siliq™** 210mg (brodalumab)	☐ **Initial:** Inject 210mg SQ at weeks 0 and 1. ☐ **Maintenance:** Beginning week 2, inject 210mg SQ every 2 weeks. **REQUIRED**: ☐ Prescriber certified through Siliq™ REMS program ☐ Patient enrolled in Siliq™ REMS program	2 syringes 2 syringes	Zero _____
☐ **Simponi®** 50mg (golimumab)	☐ Inject 50mg SQ once monthly. ☐ Other _____ For **Simponi ARIA®** infusion please locate the drug specific referral form at https://www.optimedhealthpartners.com/referrals	1 pen/syringe ☐ Other _____	 _____
☐ **Skyrizi™** 75mg (risankizumab-rzaa)	☐ **Initial:** Inject 150mg (2 injections) SQ at week 0. ☐ **Maintenance:** Beginning week 4, inject 150mg (2 injections) SQ every 12 weeks	2 syringes 2 syringes	Zero _____
☐ **Stelara®** (ustekinumab)	**Select weight/dose:** ☐ ≤ 100kg: 45mg ☐ > 100kg: 90mg ☐ **Initial:** Inject 1 dose SQ on day 0. ☐ **Maintenance:** Beginning on day 28, inject 1 dose SQ every 12 weeks **Site of Care:** OptiMed Infusion Center or home infusion nurse to administer Stelara SQ. Alternatively, the patient may be trained to self-administer as appropriate.	 ☐ 1 dose ☐ 1 dose	 Zero _____
☐ **Taltz®** 80mg (ixekizumab)	**Initial:** ☐ Weeks 0-2: Inject 160mg (2 injections) SQ at week 0 and 80mg (1 injection) SQ at week 2. ☐ Weeks 4-10: Beginning week 4, inject 80mg (1 injection) SQ once every OTHER week until week 12. **Maintenance:** ☐ Beginning week 12, inject 80mg (1 injection) SQ once every 4 weeks.	3 pens/syringes 2 pens/syringes 1 pen/syringe	Zero 1 refill _____
☐ **Tremfya®** 100mg (guselkumab)	☐ **Initial:** Inject 100mg SQ at week 0. ☐ **Maintenance:** Beginning week 4, inject 100mg SQ once every 8 weeks.	1 syringe 1 syringe	Zero _____
☐ **Xeljanz®** 5mg ^ ☐ **Xeljanz XR®** 11mg ^ (tofacitinib)	☐ Take one tablet (5mg) PO twice daily. ☐ *Dose adjustment: Take one tablet (5mg) PO ONCE daily. ☐ Take one tablet (11mg) PO once daily. ^**REQUIRED:** ANC_____ Lymph_____ Hgb_____ Date_____	☐ 60 tablets ☐ 30 tablets ☐ 30 tablets	 _____ _____
☐ Other Medication Drug _____	_____	_____	_____

*For patients with mod-to-severe renal impairment, moderate hepatic impairment, or strong CYP450 drug interactions, use half the total daily dose. Not recommended with severe hepatic impairment.
^**REQUIRED:** Attach a copy of the patient's current CBC and CMP with LFTs. These labs and lipids should be assessed at baseline and reassessed at the recommended intervals.

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

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CLEAR FORM