CEDRA

DERMATOLOGY

REFERRAL FORM

FAX: 888.889.7129
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CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone:

SSN#: Language: ☐ English ☐ Other

Address: Sex: ☐ Male ☐ Female Height: Weight: ☐ lbs ☐ kg

City: State: Zip: Known Allergies:

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#:

Address: Phone: E-mail:

City: State: Zip: Key Contact: Phone: Fax:

STATUS UPDATE PREFERENCE: ☐ Phone ☐ Text ☐ Fax ☐ E-mail:

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis: ICD-10 Code: Date of Diagnosis: OR Years With Disease

Medical Assessment (Within Last 12 Months): Psoriasis Severity: ☐ Moderate ☐ Moderate to Severe ☐ Severe

Psoriasis Type: ☐ Plaque ☐ Other (please specify)

☐ Atopic Dermatitis

Patient Evaluation:

Has patient been diagnosed with Lymphoma? ☐ Yes ☐ No Has patient been diagnosed with Heart Failure? ☐ Yes ☐ No

Which type of TB test has the patient received? ☐ PPD ☐ QFT-G Results:

Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No If NO, has treatment been initiated? ☐ Yes ☐ No

Does patient have a latex allergy? ☐ Yes ☐ No Does patient have serious/active infection? ☐ Yes ☐ No

BSA % IGSA score Is patient's platelet count >52,000 cell/uL? ☐ Yes ☐ No

PRIOR (FAILED) MEDICATION: MEDICATION REASONS FOR DISCONTINUATION

☐ BIOLOGICS:
☐ ORAL MEDS:
☐ PUVA/ UVB:
☐ TOPICALS/OTHER:

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ COSENTYX®	☐ 150 mg/mL Sensoready Autoinjector ☐ 150 mg/mL Prefilled Syringe	☐ Psoriasis Induction Dose: Inject TWO 150 mg (300 mg) syringe/autoinjector SC ONCE weekly at weeks 0 through 4. ☐ Psoriasis Maintenance Dose (Beginning At Week 5): Inject TWO 150 mg (300 mg) syringe/autoinjector SC every 4 Weeks.		
☐ DUPIXENT®	☐ 300 mg Single-dose Prefilled Syringe	☐ Initial dose of 600 mg (two 300 mg injections in different injection sites) followed by 300 mg given every other week.		
☐ ENBREL®	☐ 50 mg/mL Sureclick Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ 25 mg/0.5 mL Prefilled Syringe	☐ Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week. ☐ Other:		
☐ HUMIRA®	☐ HS Starter Package ☐ Psoriasis Starter Package ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.8 mL Prefilled Syringe	☐ HS Induction Dose (option 1): Inject four 40 mg pen SC on day 1, then two 40 mg pen SC on day 15. ☐ HS Induction Dose (option 2): Inject two 40 mg pen on day 1 and two 40 mg pen SC on day 2 , then two 40 mg pen/syringes SC on day 15. ☐ HS Maintenance Dose (beginning on Day 29): Inject ONE 40 mg pen/syringe SC every week. Plaque psoriasis: SC: ☐ Initial: Inject 80 mg SC as a single dose ☐ Maintenance: Inject 40 mg pen/syringe SC every other week beginning 1 week after initial dose		
☐ HUMIRA® Citrate Free	☐ HS Starter Package ☐ Psoriasis Starter Package ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Prefilled Syringe	☐ HS Induction Dose: Inject two 80 mg pens SC on day 1, then one 80 mg pen on day 15. ☐ HS Induction Dose: Inject one 80 mg pen SC on day 1, one 80 mg pen SC on day 2, then one 80 mg pen on day 15. ☐ HS Maintenance Dose: Inject one 40 mg pen/syringe SC once a week. Plaque psoriasis: SC: ☐ Initial: 80 mg as a single dose on day 1 ☐ Maintenance: 40 mg every other week beginning 1 week after initial dose		
☐ OTEZLA®	☐ Starter RX ☐ 30 mg	☐ Starter Pak - Use as directed. ☐ ONE tablet TWICE daily.		
☐ REMICADE® Wt:	☐ 100 mg Vial	☐ Psoriatic Arthritis Infuse 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. ☐ Plaque Psoriasis Infuse 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.		
☐ SILIQ	☐ Carton of two 210 mg/1.5 mL single-dose prefilled syringes	☐ Inject ONE prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by ONE prefilled syringe (210 mg) every 2 weeks.		
☐ STELARA®	☐ 45 mg/0.5 mL Syringe ☐ 90 mg/mL Syringe	☐ Starter dose patients weighing ≤100 kg (220 lbs): 45 mg SC at week 0 and week 4. ☐ Starter dose patients weighing >100 kg (220 lbs): 90 mg SC at week 0 and week 4. ☐ Maintenance dose patients weighing ≤100 kg (220 lbs): 45 mg SC every 12 weeks. ☐ Maintenance dose patients weighing >100 kg (220 lbs): 90 mg SC every 12 weeks. ☐ Other:		
☐ TALTZ®	☐ 80 mg/mL Prefilled Autoinjector ☐ 80 mg/mL Prefilled Syringe	☐ Starter dose: Inject 160 mg (TWO 80 mg injections) SC at week 0, then 80 mg every 2 weeks until week 12. ☐ Maintenance dose (after 12 weeks of therapy): Inject 80 mg SC every 4 weeks. ☐ Other:		
☐ TREMFYA™	☐ 100 mg/mL Syringe	☐ Inject 100 mg (ONE syringe) SC at Week 0, Week 4 and every 8 weeks thereafter.		
☐				

Date Medication Needed: Deliver To: ☐ Patient Home ☐ MD Office

Prescriber Signature: (Please sign and date below.)

Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible Date Dispense as written "DAW" Date

SUBMIT FORM CLEAR FORM