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

Dermatology (A-M)

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
☐ **Cimzia®** 200mg (certolizumab pegol)	☐ Inject 400mg (2 syringes) SQ every other week.	4 syringes	_____
	Alternative dosing for patients ≤ 90kg:		
	☐ **Initial:** Inject 400mg (2 syringes) SQ initially and at weeks 2 and 4.	6 syringes	Zero
	☐ **Maintenance:** Beginning week 6, inject 200mg SQ every OTHER week.	2 syringes	_____
☐ **Cosentyx®** 150mg (secukinumab)	**Initial:** ☐ Inject 300mg SQ at weeks 0, 1, 2, and 3.	8 pens/syringes	Zero
	☐ Inject 150mg SQ at weeks 0, 1, 2, and 3.	4 pens/syringes	Zero
	Maintenance: ☐ Beginning week 4, inject 300mg SQ once every 4 weeks.	2 pens/syringes	
	☐ Beginning week 4, inject 150mg SQ once every 4 weeks.	1 pen/syringe	_____
	☐ Other _____	☐ Other _____	_____
☐ **Dupixent®** 300mg (dupilumab)	☐ **Initial:** Inject 600mg (2 syringes) SQ at different injection sites on day 1.	2 syringes	Zero
	☐ **Maintenance:** Beginning day 15, inject 300mg SQ every OTHER week.	2 syringes	_____
☐ **Enbrel®** 50mg ☐ **Enbrel®** 25mg (etanercept)	☐ **Initial:** Inject 50mg SQ twice weekly for 12 weeks (3 months).	☐ 24 pens/syringes ☐ 24 Enbrel Mini cartridges*	Zero
	☐ **Maintenance:** Inject 50mg SQ once weekly.	☐ 4 pens/syringes ☐ 4 Enbrel Mini cartridges*	
	☐ Other _____	☐ Other _____	_____
☐ **Humira®** 40mg^ (adalimumab)	**Initial:** ☐ Psoriasis: Inject 80mg SQ on day 0, 40mg SQ on day 7, then 40mg SQ every OTHER week thereafter.	1 starter package (35-day supply)	Zero
	☐ Hidradenitis Suppurativa: Inject 160mg SQ on day 0, 80mg SQ on day 14, then 40mg SQ weekly thereafter beginning on day 28.	1 starter package (28-day supply)	Zero
	Maintenance: ☐ Inject 40mg SQ once weekly.	☐ 4 pens/syringes	
	☐ Inject 40mg SQ every OTHER week.	☐ 2 pens/syringes	
	☐ Other _____	☐ Other _____	_____
☐ **Ilumya™** 100mg (tildrakizumab-asmn)	☐ **Initial:** Inject 100mg SQ at week 0 and 4.	2 syringes	Zero
	☐ **Maintenance:** Beginning week 16, inject 100mg SQ every 12 weeks thereafter.	1 syringe	_____

*AutoTouch device must be provided to the patient by the referring provider. (Contact your Enbrel representative to request the AutoTouch device.)

^Citrate-free (CF) Humira will be dispensed unless unavailable or otherwise specified.

To order **INFLIXIMAB** IV infusion products such as **Remicade®**, **Inflectra®**, or **Renflexis®**, please locate the **INFLIXIMAB Infusion** referral form at https://www.optimedhealthpartners.com/referrals

☐ Other Medication

Drug _____ ☐ _____ _____ _____

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