Genefic
SPECIALTY PHARMACY

To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: _____

Email: _____

Direct Phone Line: _____

Cell (optional, but preferred): _____

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Dermatology Injectable Enrollment Form I - Z

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/_____ ☐**No** | **SHIP TO:** ☐ **Patient's Home** ☐**Doctor's Office** ☐ **Other:**_____

Drug		Directions & Quantity	Refills
Ilumya®	☐ Pre-filled Syringe	☐**INITIAL:** Inject 100 mg SQ at weeks 0 & 4 (Quantity: 2) ☐**MAINTENANCE:** Inject 100 mg SQ every 12 weeks (Quantity: 1)	
Siliq®	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 210 mg SQ at weeks 0 & 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)	
Skyrizi®	☐Pen ☐Pre-filled Syringe	☐**INITIAL:** Inject 150 mg SQ at weeks 0 & 4 (Quantity: 1 plus 1 refill) ☐**MAINTENANCE:** Inject 150 mg SQ every 12 weeks (Quantity: 1)	
Stelara®	☐45 mg Pre-filled Syringe	☐**INITIAL:** Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) ***WEIGHT REQUIRED*** _____ ☐**MAINTENANCE:** Inject 45 mg SQ every 12 weeks (Quantity: 1) ***Intended for weight ≤ 100 kg/220 lbs***	
	☐90 mg Pre-filled Syringe	☐**INITIAL:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) ***Intended for weight > 100 kg/220 lbs*** ☐**MAINTENANCE:** Inject 90 mg SQ every 12 weeks (Quantity: 1)	
Taltz®	☐ Auto Injector ☐ Pre-filled Syringe	☐ **STARTING:** Inject 160 mg (2 x 80 mg) SQ at week 0, then begin first induction dose 80 mg (1 x 80 mg) 2 weeks later (week 2) (Quantity: 3) ☐ **INDUCTION:** Inject 80 mg SQ every 2 weeks (weeks 4-10) (Quantity: 2 plus 1 refill) ☐ **FINAL INDUCTION:** Inject 80 mg SQ (week 12) (Quantity: 1) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)	
Tremfya®	☐ One-Press Injector ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ at week 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 100 mg SQ every 8 weeks (Quantity: 1)	

MEDICAL INFORMATION

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

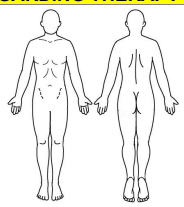
PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA /UVB	☐(_____)	☐	_____

☐Patient cannot afford ☐ Photosensitivity ☐Risk of Skin Cancer ☐ Distance from Office

☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis) ☐ Other: _____

Active TB ruled out: ☐Yes ☐No Date:___/___/____ Hep B ruled out/treated: ☐Yes ☐No Date:___/___/____



Affected Areas

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other:

BSA ____% PASI Score: ____

Date of Diagnosis: ____/____/_____

Allergies:

Additional Clinical Information:

American Academy of Dermatology Consensus Statement on Psoriasis Therapies

☐Psoriasis is covering greater than 10% of body surface area ☐ Psoriasis is on palms, soles, head and neck, or genitalia ☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
☐Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships

INJECTION TRAINING

☐Patient has received pen and injection training ☐ Physician's office to provide injection training ☐Genefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.