Genefic
SPECIALTY PHARMACY

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

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

*Pharmacy may be listed under Watson Specialty Solutions

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 Oral/Topical Enrollment Form

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
Olumiant®	☐ 2 mg Tablet	☐ Take 2 mg PO once daily (Quantity: 30)	
	☐ 4 mg Tablet	☐ Take 4 mg PO once daily (Quantity: 30)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55)	
	☐ 30 mg Tablet	☐ Take 30 mg PO twice daily (Quantity: 60)	
Sotyktu™	6 mg Tablet	☐ Take 6 mg PO once daily (Quantity: 30)	
Opzelura™	1.5 % Cream 60 gm	☐ Apply a thin layer to affected area(s) twice a day (Quantity:1 tube)	
Vtama®	1% Cream 60 gm	☐ Apply a thin layer to affected area(s) once a day (Quantity:1 tube)	
Rinvoq®	☐ 15 mg Tablet	☐ Take 15 mg PO once daily (Quantity: 30)	
	☐ 30 mg Tablet	☐ Take 30 mg PO once daily (Quantity: 30)	
	☐ 45 mg Tablet	☐ Take 45 mg PO once daily (Quantity: 30)	

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

Affected Areas

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

BSA ____% PASI Score: ____ SALT Score: ____

Date of Diagnosis: ____/____/_____

Allergies:

☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis) ☐ L63.9 Alopecia areata, unspecified

☐ L80 Vitiligo ☐ Other: _____

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

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

PRESCRIBER SIGNATURE

To Prescriber By signing this form and utilizing our services, you are also authorizing Senderra 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

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