Pharmacy SOLUTIONS

Otezla® Referral Form

Please complete the form and fax to: **855.861.4941**

877.794.9833 (phone)
10004 S. 152nd Street, Suite C
Omaha, NE 68138

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Weight	Date of Birth	Allergies

Emergency Contact & Phone	Primary Caregiver & Phone

Primary Diagnosis
- ❑ ICD-10 L40.8 Other psoriasis
- ❑ ICD-10 L40.50 Arthropathic psoriasis, unspecified
- ❑ Other:

Current or most recent therapy (include dates/duration)
- ❑ No prior disease modifying therapies

Insurance Information *Fill out entirely OR fax a copy of patient's insurance card - both sides*

Primary Insurance	Name of Insured	ID Number	Group Number	BIN	PCN

Secondary Insurance	Name of Insured	ID Number	Group Number	BIN	PCN

Other Insurance

Otezla®

❑ **Otezla® Rx**

30mg ❑ TWICE Daily ❑ ONCE Daily x30 days _____ Refills

Date titration sample provided to patient: _____ /_____ /_____

Special instructions: _____

❑ **Bridge Rx – 14 days***

- ❑ 30mg TWICE Daily x14 days 28 tablets 4 Refills
- ❑ 30mg ONCE Daily x28 days 28 tablets 2 Refills

*Bridge Rx is at no cost, for commercially insured patients only, and not contingent on purchase requirements of any kind. Enrollees in Medicare, Medicaid, and other federal and state programs, as well as Minnesota and Massachusetts residents are not eligible. Intended to promote patient access to prescribed therapy if there is a delay in determining whether commercial prescription coverage is available. Bridge Rx is dispensed by Otezla Support Plus.

❑ **Titration Starter Pack - 28 days**

Take as Directed x28 days 55 tablets 0 Refills

Prescriber/Shipping Information **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Nurse/Key Contact	Phone or Pager Number	Email

Date Shipment Needed:	Ship to: ❑ Patient ❑ Physician/Clinic ❑ Other:	Permission to Contact Patient? ❑ Yes ❑ No

Physician Signature:_____ ❑ **DAW** (Dispense as Written) **Date:** _____/_____/_____

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