



MORRISTOWN PHARMACY

COSENTYX REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960

Tel: 973 - 998 - 0287 | Fax: 973 - 998 - 0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

NEW PATIENT CURRENT PATIENT

Last updated: May 2017

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____

Diagnosis L40.8 Psoriasis L40.59 Psoriatic Arthritis M45.9 Ankylosing Spondylitis Location Scalp Groin Nails Other _____ Allergies _____

Severity Mild (<3% BSA) Moderate (3-10% BSA) Severe (>10% BSA) Patient currently on therapy? Yes No PPD Test Yes No Results _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____

Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

COSENTYX - PLAQUE PSORIASIS

New York Prescribers, please submit prescription on an original NY State prescription blank.

Starting Dose Sensoready® Pen Prefilled Syringe

Weeks 0, 1, 2, 3, and 4, then once every 4 weeks

SIG: Inject 300 mg dose SQ once weekly for 5 weeks
Each 300 mg dose is given as 2 SQ injections of 150 mg

QTY: 10 injection devices Refills: 0

Treatment Start Date (if applicable) _____

Maintenance Supply Sensoready® Pen Prefilled Syringe

Once every 4 weeks

SIG: Inject 300 mg dose SQ once every 4 weeks
Each 300 mg dose is given as 2 SQ injections of 150 mg

Other: _____

1 Month 2 Months 3 Months

QTY: _____ Refills: _____

COSENTYX - PSORIATIC ARTHRITIS & ANKYLOSING SPONDYLITIS

New York Prescribers, please submit prescription on an original NY State prescription blank.

With Loading Dose Sensoready® Pen Prefilled Syringe

Weeks 0, 1, 2, 3, and 4, then once every 4 weeks

SIG: Inject 150 mg dose SQ once weekly for 5 weeks

QTY: 10 injection devices Refills: 0

Treatment Start Date (if applicable) _____

Without Loading Dose Sensoready® Pen Prefilled Syringe

SIG: Inject 150 mg dose SQ once every 4 weeks

Other: _____

1 Month 2 Months 3 Months

QTY: _____ Refills: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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Please fax completed form to **Morristown Pharmacy** at 973 - 998 - 0288

Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.