P U B L I X
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Psoriatic Arthritis Referral Form

Publix Specialty Pharmacy (#3212)

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Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ____________________ Patient's Last Name: ____________________ Date of Birth: ___/___/_____ ☐ Male ☐ Female

Address: ____________________ City: ____________________ State: __________ Zip: ____________

Primary Phone Number: (_____) ____________________ Alt. Phone Number: (_____) ____________________ Caregiver name: ____________________

Clinical Information [Attach copy of labs and office notes]

Diagnosis code(s): ____________ Diagnosis: ☐ Psoriatic Arthritis (PsA) ☐ Psoriasis (PsO) ☐ Other: ____________________

Treatment status: ☐ New to therapy, previously denied by insurance: ☐ No ☐ Yes, include copy of denial letter Enroll in copay card/ bridge program if available and eligible: ☐ No ☐ Yes

☐ Continuation of therapy, start date: ___/___/_____ Is the patient on samples? ☐ No ☐ Yes Weight: ______ ☐ kg ☐ lb, Height: ______ ☐ cm ☐ in

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: ___/____/______ Allergies: ☐ NKDA ☐ Other: ____________________

Prior therapy, reason for discontinuation, and treatment dates: ____________________

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY	REFILLS
☐ Cimzia (certolizumab pegol)	☐ Starter Kit: 200 mg/mL PFS	Initial Dose: Inject 400 mg (2 x 200 mg) SC on days 1, 15, and 29	3 doses	0
	☐ 200 mg/mL PFS ☐ 200 mg vial	Maintenance Dose: ☐ Inject 400 mg (2 x 200 mg) SC every 4 weeks ☐ Inject 200 mg SC every 2 weeks	☐ 28 days ☐ 84 days	_______
☐ Cosentyx (secukinumab)	☐ 150 mg/mL Sensoready pen ☐ 150 mg/mL PFS	Initial Dose: ☐ Inject 150 mg SC once a week for 5 weeks (on days 1, 8, 15, 22, and 29)	56 days	0
		Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg (2 x 150 mg) SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Enbrel (etanercept)	☐ 50 mg/mL SureClick pen ☐ 50 mg/mL PFS ☐ 25 mg/0.5 mL PFS	☐ Inject 50 mg SC once a week ☐ Other: ____________________	☐ 28 days ☐ 84 days	_______
☐ Humira (adalimumab)	☐ 40 mg pen ☐ 40 mg PFS	☐ Inject 40 mg SC every 2 weeks ☐ Other: ____________________	☐ 28 days ☐ 84 days	_______
☐ Orencia (abatacept)	☐ 125 mg/mL ClickJect pen ☐ 125 mg/mL PFS	Inject 125 mg SC once a week	☐ 28 days ☐ 84 days	_______
	☐ 250 mg vial *(IV use only)* Patient weight: _______	☐ Infuse ________ mg IV over 30 min x 1 dose, then within 24 hours start SC dosing	1 dose	0
		☐ Infuse ________ mg IV over 30 min on days 1, 15, and 29 then every 4 weeks	☐ 28 days ☐ 84 days	_______
	Include: ☐ Sterile water for inj 10 mL vial ☐ Sodium chloride 0.9% inj 100 mL bag	Use 10 mL to reconstitute each 250 mg abatacept vial before dilution Dilute reconstituted abatacept to a final concentration of no more than 10 mg/mL	QS	_______
☐ Otezla (apremilast)	☐ Starter Pack: 55 tablets	Initial dose: Take as directed per package instructions	28 days	0
	☐ 30mg tablet	Maintenance dose: ☐ Take 1 tab PO BID ☐ Take 1 tab PO once a day (for severe renal impairment)	☐ 30 days ☐ 90 days	_______
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)	100 mg vial Patient weight: _______	Initial Dose: ☐ Infuse ______ mg (____ mg/kg) IV over at least 2 hours on days 1, 15, and 43	3 doses	0
		Maintenance Dose: ☐ Infuse ______ mg (____ mg/kg) IV over at least 2 hours every 8 weeks	56 days	_______
	Include: ☐ Sterile water for inj 10 mL vial ☐ Sodium chloride 0.9% inj 250 mL bag	Use 10 mL to reconstitute each 100 mg infliximab vial before dilution Dilute reconstituted infliximab to a final concentration of 0.4 to 4 mg/mL	QS	_______
☐ Simponi (golimumab)	☐ 50 mg/0.5 mL SmartJect pen ☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Stelara (ustekinumab)	45 mg/0.5 mL PFS	Initial Dose: ☐ Inject 45 mg SC on day 1, then 4 weeks later on day 29	2 doses	0
		☐ Maintenance Dose: Inject 45 mg SC every 12 weeks	84 days	_______

Prescriber Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____] Use Cover My Meds: ☐ No ☐ Yes

Name: ____________________ DEA# ____________________ NPI # ____________________

Address: ____________________ City: ____________________ State: ___________ Zip: ____________

Office Phone Number: (_______) ____________________ Fax Number: (_______) ____________________ Office Contact: ____________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

For states requiring hand written expressions to prevent substitution, write here:

Prescriber's signature: ____________________ ____________________
(stamps not accepted) ☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

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