

# REFERRAL FORM

## FAX Referral Form To

803-461-0394  
Toll Free Fax  
866-437-6728



## Contact Number

803-461-0393  
Toll Free Number  
866-437-6717

630 Kilbourne Rd., Columbia, SC 29205

Long's Pharmacists: Kimberly Taylor, RPh    Christi Epps, PharmD    Jody Yates, RPh

Date: \_\_\_\_\_ Date Needed By: \_\_\_\_\_ Ship Medication To:  Patient  MD Office  Other

### Physician Information

Physician/Office Name:		Phone:
Address:		Fax:
DEA Number:	State License Number:	Contact:

### Patient - Information

**PLEASE: Fax front and back copy of the patient's insurance card(s)**

Patient Name:	Date of Birth:	Pt. Phone Number:	
Patient Shipping Address:	City:	State:	Zip:
Pt. Social Security Number	Name of Insured:		
Insurance:	ID Number:	Group Number:	

### Clinical Information

Prior FAILED Medications:	Dose/Strength	Duration of Treatment
<input type="checkbox"/> Dovonex	_____	_____
<input type="checkbox"/> Methotrexate	_____	_____
<input type="checkbox"/> Cyclosporine	_____	_____
<input type="checkbox"/> Soriatane	_____	_____
<input type="checkbox"/> PUVA/UVB	_____	_____
<input type="checkbox"/> Other:	_____	_____

#### Diagnosis:

- |                                                    |                                 |
|----------------------------------------------------|---------------------------------|
| <input type="checkbox"/> 696.1 Psoriasis           | Allergies: _____                |
| <input type="checkbox"/> 696.0 Psoriatic Arthritis | % BSA (Body Surface Area) _____ |
| <input type="checkbox"/> Other: _____              | Other Comments: _____           |

Follow up with MD in:  3 month follow up     6 month follow up     9 month follow up     12 month follow up

Treatment	Dose/Strength	Dose/Frequency	Quantity	Refills
<input type="checkbox"/> Enbrel	SureClick 50mg/ml	#8 vials; 50mg SC twice weekly for 3 months	_____	_____
<input type="checkbox"/> Enbrel	SureClick 50mg/ml	#4 vials; 50mg SC once weekly	_____	_____
<input type="checkbox"/> Enbrel	50mg/mL Prefilled Syringe	#8 vials; 50mg SC twice weekly for 3 months	_____	_____
<input type="checkbox"/> Enbrel	50mg/mL Prefilled Syringe	#4 vials; 50mg SC once weekly	_____	_____
<input type="checkbox"/> Enbrel	25mg/vial	#8 vials; 25 mg SC twice weekly, 72-96 hours apart	_____	_____
<input type="checkbox"/> Humira	Humira Pen 40mg/ml	#2; 40mg EOW	_____	_____
<input type="checkbox"/> Humira	Humira Pen 40mg/ml	#4; 40mg Every Week	_____	_____
<input type="checkbox"/> Humira	40mg/ml Prefilled Syringe	#2 ; 40mg EOW	_____	_____
<input type="checkbox"/> Humira	40mg/ml Prefilled Syringe	#2 ; 40mg Every Week	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____

Notes:

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Dispense as Written	Date	Substitution Permitted	Date
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