BERGEN AVE DRUGS
SPECIALTY PHARMACY

COSENTYX REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306
Tel 201.521.0545 | Fax 201.521.0546

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 ☐ M45.9Ankylosing 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 **Bergen** at **201.521.0546**

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