

## CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. Prescription Form

Please fax form to **1.877.800.4791** with a copy of member insurance ID card. For questions, please call **1.888.OncoSRx (662.6779)**.

### Patient Information

|                        |  |                        |      |
|------------------------|--|------------------------|------|
| Last Name:             |  | First Name:            |      |
| Home Phone Number: ( ) |  | Work Phone Number: ( ) |      |
| Home Address:          | City:  | State:                 | Zip: |
| Date of Birth:         | Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Other (List): |                        |      |
| Insurance ID #:        | Group #:   |                        |      |

### Physician Information

|                      |                   |                 |      |
|----------------------|-------------------|-----------------|------|
| MD Name:             |                   |                 |      |
| MD DEA #:            |                   | NPI #:          |      |
| Address:             | City:             | State:          | Zip: |
| Office Contact Name: | Phone Number: ( ) | Fax Number: ( ) |      |

### Primary Diagnosis

Primary ICD9 (Code): \_\_\_\_\_

Primary Diagnosis (In Words): \_\_\_\_\_

Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?  Yes  No

### Clinical Information

- Is the patient naive to therapy or continuing therapy?  Naive  Continuing If continuing, how long has the patient been on this medication? \_\_\_\_\_
- Has a dermatologist recommended or requested therapy?  Yes  No
- Is the patient receiving a tumor necrosis factor (TNF)-blocking agent?  Yes  No
- Will the TNF-blocking agent be discontinued?  Yes  No
- Has the patient tried or is the patient a candidate for anti-psoriatic therapy or phototherapy?  Yes  No

### Prescription Information

|   |           |           |
|---|-----------|-----------|
| Drug Name:  | Strength: | Quantity: |
| SIG:  |           | Refills:  |
| <input type="checkbox"/> 30 Day <input type="checkbox"/> 90 Day |           |           |

### Physician Signature Required

Information on this form is accurate as of this date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

MD Signature: \_\_\_\_\_