Dermatology Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. *Prescribers are reminded patients may choose any pharmacy*

1. Patient Information

Patient Name:	DOB:	Sex: ☐ Male ☐ Female	Weight	☐ Lbs.	☐ kg
Preferred Phone:	Known Allergies:				
Address	City:	State:	Zip:		

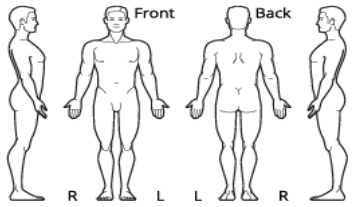
Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name:	NPI:	Tax ID No:	
Prescriber Phone:	Prescriber Fax:	Key Contact	
Address	City:	State:	Zip:

3. Diagnosis/Clinical Information

Diagnosis:	ICD-10	
Date of Diagnosis (or years with disease):		
Has patient been previously treated for this condition?	☐ Yes	☐ No
If yes, medication/therapy failed (length of therapy):		
Has Patient received PPD (tuberculosis) Skin Test?	☐ Yes	☐ No
Has Hepatitis B been ruled out or treatment been initiated?	☐ Yes	☐ No
Does patient have a latex allergy?	☐ Yes	☐ No



_____% BSA
Affected by Psoriasis

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Cimzia®	☐ Starter Kit ☐ 200 mg Prefilled Syringe	☐ **Starter Dose:** 400 mg SC weeks 0, 2 and 4 **Maintenance Dose:** ☐ 200 mg SC every 2 weeks ☐ 400 mg SC every 4 weeks	28-day supply	
☐ Cosentyx®	☐ 150 mg Prefilled Syringe ☐ 300 mg Prefilled Syringe ☐ 150 mg Sensoready® Pen ☐ 300 mg Sensoready® Pen (2PenPck) ☐ 300 mg UnoReady Pen	☐ **Starter Dose:** Inject SC at weeks 0, 1, 2, 3 and 4 ☐ **Maintenance Dose:** Inject SC every 4 weeks	28-day Supply	
☐ Dupixent®	☐ 300 mg/2ml Prefilled Pen ☐ 200 mg/1.14ml Prefilled Pen ☐ 300 mg/2ml Prefilled Syringe ☐ 200 mg/1.14ml Prefilled Syringe	☐ **Starter Dose:** 600 mg SC divided in 2 different injection sites ☐ **Maintenance dose:** 300 mg SC every other week	28-day supply	
☐ Enbrel®	☐ 50 mg/ml Mini ☐ 50 mg/ml Prefilled Syringe ☐ 50 mg/ml SureClick™ Autoinjector ☐ 25 mg/0.5ml Prefilled Syringe	☐ Inject 25 mg SC TWICE a week ☐ Inject 50 mg SC ONCE a week ☐ Other:	28-day supply	
☐ Humira®	☐ 20 mg/0.1ml Citrate-Free Prefilled Syringe ☐ 40 mg/0.4ml Citrate-Free Pen ☐ 40 mg/0.4ml Citrate-Free Prefilled Syringe ☐ Citrate-Free Starter Kit ☐ 80 mg / 0.8 mL citrate-free Pen	**Starter Dose:** ☐ Hidradenitis Suppurativa: Inject 160 mg SC in day 1, then 80 mg on day 15 ☐ Plaque Psoriasis; Inject 80 mg SC day 1, then 40mg on day 8, and then 40mg every 2 weeks thereafter ☐ Other: **Maintenance Dose:** ☐ Hidradenitis Suppurativa: Inject 40 mg SC on day 29 and then every week thereafter ☐ Hidradenitis Suppurativa: Inject 80 mg SC on day 29 then every other week. ☐ Plaque Psoriasis: Inject 40 mg SC every 2 weeks	28-day supply	
☐ Opzelura™	☐ 1.5% Cream, 60 mg tube	☐ Directions: Do not apply more than one 60 gm tube per week	28-day supply	
☐ Otezla®	☐ 4 Week Starter Pack ☐ 30 mg Tablets	☐ **Starter Dose:** 28 Days as directed ☐ **Maintenance Dose:** Take 1 Tablet by mouth twice daily		
☐ Rinvoq®	☐ 15 mg tablet, extended release	☐ Take one 15 mg tablet by mouth daily	30-day supply	
☐ Skyrizi®	☐ 150 mg/mL Single Dose Pen ☐ 150 mg/mL Single Dose Syringe	☐ Starter Dose:150 mg SC at Week 0, Week 4 ☐ Maintenance Dose: 150 mg SC every 12 weeks		
☐ Stelara®	☐ 45 mg/0.5 ml Prefilled Syringe ☐ 90 mg/1 ml Prefilled Syringe	**Starter Dose:** ☐ Inject 45 mg SC (patient <100 kg) at Day 1 ☐ Inject 90 mg SC (patient >100 kg) at Day 1 **Maintenance Dose:** ☐ Inject 45 mg SC (patient <100 kg) 29 days after starter dose and then every 12 weeks ☐ Inject 90 mg SC (patient >100 kg) 29 days after starter dose and then every 12 weeks ☐ Other:		
☐ Taltz®	☐ Autoinjector 80 mg/mL ☐ Prefilled Syringe 80 mg/mL	☐ **Starter Dose**: 160 mg SC at week 0; then inject 80 mg SC at weeks 2,4,6,8,10 & 12 ☐ **Maintenance Dose**: 80 mg SC every 4 weeks		
☐ Tremfya®	☐ 100 mg/mL Single Dose Pen ☐ 100 mg/mL Single Dose Syringe	☐ Inject 100 mg SC at weeks 0, 4, and then every 8 weeks thereafter		
☐				

Dispensing Options: ☐ Pick-Up | Deliver To: ☐ Patient's Home ☐ Prescriber's Office

Prescriber Signature: **Date:**

I authorize Evergreen Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.