Dermatology Referral Form

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

1. Patient Information

Patient Name: _____ Birthdate: _____ 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)

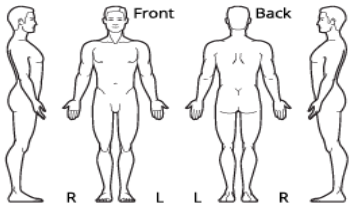
2. Prescriber Information

Prescriber Name: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____

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 ☐ 200 mg Lyophilized Vial	☐ **Starter Dose:** 400 mg SC weeks 0, 2 and 4 **Maintenance Dose:** ☐ 400 mg (given as 2 SC inj of 200 mg each) every other week ☐ 200 mg SC every 2 weeks ☐ 400 mg SC every 4 weeks	28-day supply	0
☐ Cosentyx®	☐ 150 mg Prefilled Syringe ☐ 300 mg Prefilled Syringe ☐ 150 mg Sensoready® Pen ☐ 300 mg Sensoready® Pen	☐ **Starter Dose:** Inject SC at weeks 0, 1, 2, 3 and 4 ☐ **Maintenance Dose:** Inject SC every 4 weeks	28-day supply	0
☐ Dupixent®	☐ 300 mg/2ml Prefilled Syringe	☐ **Starter Dose:** 600 mg SC divided in 2 different injection sites ☐ **Maintenance dose:** 300 mg SC every other week	28-day supply	0
☐ Enbrel®	☐ 50 mg/ml Mini ☐ 50 mg/ml Prefilled Syringe ☐ 50 mg/ml SureClick™ Autoinjector ☐ 25 mg/0.5ml Prefilled Syringe	☐ Inject 50 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	**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 ☐ Plaque Psoriasis: Inject 40 mg SC every 2 weeks	28-day supply	_____ ***0 refills for starter dose***
☐ Ilumya™	☐ 100 mg Prefilled Syringe	☐ 100 mg SC day 0 and 28, then every 12 weeks	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	28-day supply	
☐ Siliq®	☐ 210 mg/1.5 ml Prefilled Syringe	☐ Starter Dose: 210 mg SC on weeks 0, 1, 2 ☐ Maintenance Dose: 210 mg SC every 2 weeks	28-day supply	0
☐ Skyrizi®	☐ 75 mg/0.83 mL Prefilled Syringe	☐ Starter Dose:150 mg SC at Week 0, Week 4 ☐ Maintenance Dose: 150 mg SC every 12 weeks	28-day supply	
☐ 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: _____	28-day supply	0
☐ 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	28-day supply	0
☐ Tremfya®	☐ 1 mL Prefilled Syringe	☐ Inject 100 mg SC at weeks 0, 4, and then every 8 weeks thereafter	28-day supply	
☐ _____				

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

Prescriber Signature: Prescriber, please sign and date below

	Date

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