DERMATOLOGY (A-F) REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

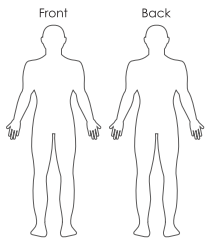
Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **L73.2** Hidradenitis Suppurativa
☐ **Yes** ☐ **No** Currently on therapy? ☐ **Yes** ☐ **No** Active TB ruled out? Date _____
☐ **Yes** ☐ **No** Active Hep B ruled out? Date_____
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Acitretin				
Adalimumab				
Clobetasol				
Cyclosporine				
Elidel				
Enbrel				
Eucrisa				
Humira				
Leflunomide				
Methotrexate				
Stelara				
Sulfasalazine				
UVA Phototherapy				
UVB Phototherapy				



Scoring Tool Used:
☐ BSA ☐ EASI ☐ ISGA
☐ POEM ☐ SCORAD
_____% or Score: _____

Severity:
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

Location/Affected Areas:
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

PRESCRIPTION

☐ **CIMZIA**
☐ **Starter dose**: 400 mg SQ initially and at weeks 2 & 4 QTY: 6 Refills: 0
Maintenance dose:
☐ 200 mg subcutaneously every 2 weeks **OR**
☐ 400 mg subcutaneously every 4 weeks QTY: _____ Refills: _____
Plaque Psoriasis: ☐ 400 mg subcutaneously every other week.
For patients with weight ≤ 90 kg: a dose of 400 mg subcutaneously initially and at Weeks 2 and 4, followed by 200 mg subcutaneously every other week
QTY: _____ Refills: _____

COSENTYX ***New York Prescribers, please submit prescription on an original NY State prescription blank.***
Starting Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
Weeks 0, 1, 2, 3, & 4, then once every 4 weeks
☐ SIG: Inject 300 mg dose subcutaneously once weekly for 5 weeks
Each 300 mg dose is given as 2 SQ injections of 150 mg
QTY: 10 injection devices Refills: 0
Maintenance Supply ☐ Sensoready® Pen ☐ Prefilled Syringe
Once every 4 weeks
☐ SIG: Inject 300 mg dose subcutaneously 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: _____

☐ **DUPIXENT® 300 mg/2 mL solution in a single-dose PFS**
☐ Initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week
QTY:_____ Refills: _____

☐ **ENBREL 50 mg/ml** *not to be used in pediatric weighing less than 63 kg (138 lbs)*
☐ SureClick (prefilled autoinjector) ☐ PFS ☐ Enbrel Mini™/AutoTouch
☐ **Starting Dose:** 50 mg subcutaneously BIW *(72-96 hours apart)*
QTY: 8 Refills _____
*Psoriasis: The recommended starting adult dose is for 3 months
(Max of 2 refills), please specify number of refills
☐ **Maintenance Dose:** 50 mg subcutaneously weekly QTY: 4 Refills _____

☐ **ENBREL 25 mg/ml** *not to be used in pediatric weighing less than 31 kg (68 lbs)*
☐ 25 mg Multiple-Use ☐ 25 mg/0.5 ml PFS
☐ Vial 25 mg subcutaneously BIW *(72-96 hrs apart)*
QTY: 8 Refills: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

DERMATOLOGY (G-R) REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
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Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
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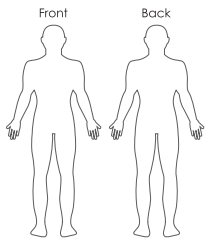
License# _____
NPI# _____

ICD-10 Code ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **L73.2** Hidradenitis Suppurativa
☐ **Yes** ☐ **No** Currently on therapy? ☐ **Yes** ☐ **No** Active TB ruled out? Date _____
☐ **Yes** ☐ **No** Active Hep B ruled out? Date_____
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Acitretin				
Adalimumab				
Clobetasol				
Cyclosporine				
Elidel				
Enbrel				
Eucrisa				
Humira				
Leflunomide				
Methotrexate				
Stelara				
Sulfasalazine				
UVA Phototherapy				
UVB Phototherapy				



Scoring Tool Used:
☐ BSA ☐ EASI ☐ ISGA
☐ POEM ☐ SCORAD
_____% or Score: _____

Severity:
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

Location/Affected Areas:
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

PRESCRIPTION

Psoriasis ☐ **HUMIRA** 80 mg/0.8mL | ☐ PFS ☐ Pens
☐ **HUMIRA Citrate-Free** **Dose:** ☐ 40 mg/0.4mL | ☐ PFS ☐ Pens
☐ **Starting Dose:** Inject 80 mg initial dose subcutaneously on day 1, followed by 40 mg every other week starting one week after initial dose QTY:_____ NO REFILLS
☐ **Maintenance Dose:** Inject 40 mg subcutaneously every other week QTY:_____ Refills: _____

Hidradenitis Suppurativa ☐ **HUMIRA** ☐ **HUMIRA Citrate-Free**
Dose: ☐ 40 mg/0.8mL ☐ 80 mg/0.8mL | ☐ PFS ☐ Pens
☐ **Starting Dose:** Inject four 40 mg pens/syringes subcutaneously on day 1 OR inject two 40 mg pen/syringes daily for 2 days, THEN two 40mg pens/syringes on day 15, QTY: 6 NO REFILLS
☐ **Maintenance Dose:** Inject 40 mg subcutaneously every week, beginning day 29 QTY:_____ Refills: _____

☐ **RASUVO®**
☐ 10mg ☐ 12.5mg ☐ 15mg
☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg
SIG: Inject _____mg subcutaneously weekly QTY: 4 Refill: _____

☐ **ILUMYA 100mg/mL PFS**
☐ **Starting Dose:** Initial dose of 100 mg subcutaneous injection at week 0 and week 4 QTY: 2 Refills: 0
☐ **Maintenance Dose:** 100 mg subcutaneous injection given every 12 weeks thereafter QTY: 1 Refills: _____
****ILUMYA should only be administered by a healthcare provider****

☐ **OTEZLA®**
☐ **Titration Starter Pack**
SIG: Take as directed QTY: 55 for 28 days
☐ **Maintenance**: 30 mg
SIG: Take 30 mg twice a day QTY: 60 Refills: _____

☐ **OTEZLA® Bridge Rx 30 mg**
☐ SIG: Take 30 mg twice a day for 14 days QTY: 28 Refills: 12
☐ SIG: Take 30 mg once a day for 28 days QTY: 28 Refills: 6
****For direct to manufacture program ONLY****

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Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

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DERMATOLOGY (S-Z) REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **L73.2** Hidradenitis Suppurativa
☐ **Yes** ☐ **No** Currently on therapy? ☐ **Yes** ☐ **No** Active TB ruled out? Date _____
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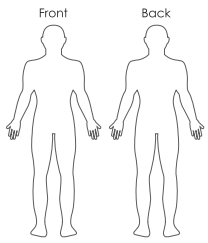
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Acitretin				
Adalimumab				
Clobetasol				
Cyclosporine				
Elidel				
Enbrel				
Eucrisa				
Humira				
Leflunomide				
Methotrexate				
Stelara				
Sulfasalazine				
UVA Phototherapy				
UVB Phototherapy				



Scoring Tool Used:
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☐ POEM ☐ SCORAD
_____% or Score: _____

Severity:
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

Location/Affected Areas:
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

PRESCRIPTION

☐ **SILIQ 210 mg/mL** PFS
☐ **Initial dose:** Inject 210 mg SQ on weeks 0, 1, and 2 QTY: 2 Refills: 0
☐ **Maintenance Dose:** Inject 210 mg subcutaneously every 2 weeks thereafter QTY: 2 Refills: _____

Psoriatic Arthritis ☐ **SIMPONI®**
☐ **50 mg/0.5ml SmartJect™ (Autoinjector)**
Sig: Inject 1 single-use Autoinjector SQ once monthly QTY: 1 Refills: _____
☐ **50 mg/0.5mL PFS**
Sig: Inject 1 single-use PFS SQ once monthly QTY: 1 Refills: _____

Plaque Psoriasis ☐ **SKYRIZI 75 mg/0.83 mL PFS**
☐ **Start Dose:** Inject 150mg (two 75 mg injections) subcutaneously at week 0, week 4 QTY: 4 Refills: 0
☐ **Maintenance Dose:** Inject 150mg (two 75 mg injections) subcutaneously every 12 weeks thereafter QTY: _____ Refills: _____

STELARA ☐ **45 mg** OR ☐ **90mg**
☐ **Start Dose:** Inject ____ mg subcutaneously initially and 4 weeks later QTY: 2 Refills: _____
☐ **Maintenance Dose:** Inject ____ mg subcutaneously every 12 weeks QTY: 1 Refills: _____

☐ **TREMFYA 100 mg/mL PFS**
☐ **Initial dose:** 100 mg subcutaneous injection at week 0 and week 4
☐ **Maint Dose:** 100 mg subcutaneous injection given every 8 weeks thereafter QTY: _____ Refills: _____

Psoriasis **TALTZ 80mg/mL** ☐ Autoinjector ☐ Prefilled Syringe
☐ **Start Dose:** Inject 160mg SQ on Day 1 QTY: 2 pens Refills: 0
☐ **Induction Dose:** Inject 80 mg subcutaneously starting week 2 and every 2 weeks through week 12 QTY: 6 pens Refills: 0
☐ **Maintenance Dose:** Inject 80mg subcutaneously every 4 weeks QTY: 1 pen Refills: ____

Psoriatic Arthritis **TALTZ 80mg/mL** ☐ Autoinjector ☐ Prefilled Syringe
☐ **Start Dose:** Inject 160 mg SQ at week 0 QTY: 2 Refills: 0
☐ **Maint Dose:** Inject 80mg SQ every 4 weeks QTY: ____ Refills: ____

Psoriatic Arthritis **XELJANZ®** ☐ 5 mg tab **XELJANZ XR®** ☐ 11 mg tab
Used in combination with nonbiologic DMARDs:
☐ 5 mg twice daily OR ☐ 11 mg once daily QTY: _____ Refills: _____
☐ Other: _____ QTY: _____ Refills: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

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