

DERMATOLOGY REFERRAL FORM (A-D)

PHONE 888.370.1724 | FAX 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email		Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment		Therapy Start Date			
Sample/Starter Product Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Provide Qty:		Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No		TB Test Results		Test Date	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Latex <input type="checkbox"/> Drug Allergies (please list)		<input type="checkbox"/> Other (please list)			
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted	
ICD-10 Codes <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified <input type="checkbox"/> L40.0 Psoriasis vulgaris <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> L73.2 Hidradenitis, suppurativa <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> Date of Diagnosis _____					

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must *handwrite* "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Adbry	<input type="checkbox"/> 150 mg/ml PFS	Initial Dose: <input type="checkbox"/> Inject 600 mg (4x150 mg injections) SC on Day 1, followed by 300 mg (2x150 mg injections) SC on Day 15 <i>Note: Multiple injections to be administered at different injection sites within the same body area</i> Maintenance Dose: <input type="checkbox"/> Inject 300 mg (2x150 mg injections) SC every other week. <input type="checkbox"/> Inject 300 mg (2x150 mg injections) SC every 4 weeks (body weight <100 kg & have achieved clear or almost clear skin after 16 weeks of treatment) <i>Note: Multiple injections to be administered at different injection sites within the same body area</i>	6	
<input type="checkbox"/> Cibinqo	<input type="checkbox"/> 50 mg Tablet <input type="checkbox"/> 100 mg Tablet <input type="checkbox"/> 200 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food, at the same time each day.	30	
<input type="checkbox"/> Cimzia*	<input type="checkbox"/> 200mg x2 PFS <input type="checkbox"/> 200mg x2 Vials	<input type="checkbox"/> (PsO) Inject 400mg (as two-200mg injections) subcutaneously every other week <input type="checkbox"/> (PsO) Alternate load (pt ≤90kg): inject 400mg (as two-200mg injections) at weeks 0, 2, and 4 <input type="checkbox"/> (PsO) Alternate maintenance (pt ≤90kg): Inject 200mg subcutaneously every other week <input type="checkbox"/> (PsA) Starter Kit: Inject 400mg (as two-200mg injections) subcutaneously at weeks 0, 2, and 4 <input type="checkbox"/> (PsA) Maintenance: Inject 400mg subcutaneously every 4 weeks <input type="checkbox"/> (PsA) Maintenance: Inject 200mg subcutaneously every 2 weeks		
<input type="checkbox"/> Cosentyx*	300mg (2x150mg) <input type="checkbox"/> Pen <input type="checkbox"/> PFS 150mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Load: Inject 300mg subcutaneously on week 0, 1, 2, 3 <input type="checkbox"/> Maintenance: Inject 300mg subcutaneously on week 4, then every 4 weeks thereafter <input type="checkbox"/> Load: Inject 150mg subcutaneously on week 0, 1, 2, 3 <input type="checkbox"/> Maintenance: Inject 150mg subcutaneously on week 4, then every 4 weeks thereafter		
<input type="checkbox"/> Dupixent*	300mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS w/Shield 200mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS w/Shield	<input type="checkbox"/> Load: Inject 600mg (as two-300mg injections in different sites) on day 1, then inject 300mg every other week starting on day 15 <input type="checkbox"/> Maintenance: Inject 300mg subcutaneously every other week <input type="checkbox"/> Load: Inject 400mg (as two-200mg injections in different sites) on day 1, then inject 200mg every other week starting on day 15 <input type="checkbox"/> Maintenance: Inject 200mg subcutaneously every other week		

Prescriber Signature

Date

Supervising Physician Signature (where required by state law)

Date

DAW (Dispense as Written)

Date

Brand Necessary (must *handwrite*)

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DERMATOLOGY REFERRAL FORM (E-O)

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PATIENT INFORMATION

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Email	Home Phone	Work Phone		Cell Phone	
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PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment		Therapy Start Date			
Sample/Starter Product Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Provide Qty:		Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No		TB Test Results		Test Date	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Latex <input type="checkbox"/> Drug Allergies (please list)		<input type="checkbox"/> Other (please list)			
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted	
ICD-10 Codes <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified <input type="checkbox"/> L40.0 Psoriasis vulgaris <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> L73.2 Hidradenitis, suppurativa <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> Date of Diagnosis _____					

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Enbrel*	<input type="checkbox"/> 50 mg SureClick Auto-Injector <input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 50 mg Mini Cartridge <input type="checkbox"/> 25 mg PFS <input type="checkbox"/> 25 mg SDV	<input type="checkbox"/> Load: Inject 50mg subcutaneously twice a week, 72-96 hours apart x3 months <input type="checkbox"/> Maintenance: Inject 50mg subcutaneously once a week <input type="checkbox"/> Other: _____ Pediatric Weight: _____ Date Taken: _____		
<input type="checkbox"/> Eucrisa	<input type="checkbox"/> 2% Ointment <input type="checkbox"/> 60gm <input type="checkbox"/> 100gm	<input type="checkbox"/> Apply a thin layer to affected area(s) twice daily		
<input type="checkbox"/> Humira CF (Plaque Psoriasis)	<input type="checkbox"/> Starter Pack (CF): 80 mg/0.8 mL, 40 mg/0.4 mL PENS	Initial Dose: <input type="checkbox"/> Inject 80 mg SC on day 1, followed by 40 mg SC on Day 8 & Day 22	1 Starter Pack	
	<input type="checkbox"/> 40 mg/0.4 mL PFS (CF) <input type="checkbox"/> 40 mg/0.4 mL PEN (CF)	Maintenance Dose: <input type="checkbox"/> Inject 40 mg SC every other week. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Humira CF (Hidradenitis Suppurativa)	<input type="checkbox"/> Starter Pack (CF): 80 mg/0.8 mL PENS	Initial Dose: <input type="checkbox"/> Inject 160mg (2 x 80 mg) SC on Day 1, then 80mg SC two weeks later (on Day 15). <input type="checkbox"/> Inject 80 mg SC on Day 1, 80 mg SC on Day 2, then 80 mg SC two weeks later (on Day 15).	1 Starter Pack	
	<input type="checkbox"/> 40 mg/0.4 mL (CF) PEN <input type="checkbox"/> 40 mg/0.4 mL (CF) PFS <input type="checkbox"/> 80 mg/0.8 mL (CF) PEN	Maintenance Dose: <input type="checkbox"/> Inject 40 mg SC on Day 29 and every week thereafter. <input type="checkbox"/> Inject 80 mg SC on Day 29 and every other week thereafter.		
<input type="checkbox"/> Humira CF (Psoriatic Arthritis)	<input type="checkbox"/> 40 mg/0.4 mL (CF) PEN <input type="checkbox"/> 40 mg/0.4 mL (CF) PFS	Maintenance Dose: <input type="checkbox"/> Inject 40mg SC every other week. Other: _____		
<input type="checkbox"/> Ilumya	<input type="checkbox"/> 100mg/ml PFS	<input type="checkbox"/> Inject 100mg at Weeks 0,4, and every 12 weeks thereafter		
<input type="checkbox"/> Opzelura	<input type="checkbox"/> 1.5% Cream	Apply a thin layer twice daily to affected areas; application area should not exceed 20% BSA. Do not use more than 60 grams (1 tube) per week. Discontinue when signs/symptoms resolve.		
<input type="checkbox"/> Orencia	<input type="checkbox"/> 250mg Vial <input type="checkbox"/> 125mg PFS <input type="checkbox"/> 125mg Clickjet Pen	Inject 125mg Subcutaneously once weekly		
<input type="checkbox"/> Otezla*	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Take 1 tablet on day 1 then twice daily as directed _____ <input type="checkbox"/> Take 1 tablet by mouth twice daily _____		

Prescriber Signature

Date

Supervising Physician Signature (where required by state law)

Date

DAW (Dispense as Written)

Date

Brand Necessary (must *handwrite*)

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DERMATOLOGY REFERRAL FORM (P-T)

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email		Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment		Therapy Start Date			
Sample/Starter Product Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Provide Qty:		Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No		TB Test Results		Test Date	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Latex <input type="checkbox"/> Drug Allergies (please list) <input type="checkbox"/> Other (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted	
ICD-10 Codes <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified <input type="checkbox"/> L40.0 Psoriasis vulgaris <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> L73.2 Hidradenitis, suppurativa <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> Date of Diagnosis _____					

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Remicade <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis <input type="checkbox"/> Avsola	<input type="checkbox"/> Vial (weight based)	<input type="checkbox"/> Starter dose: 5mg/kg (_____ mg) IV at weeks 0,2 and 6 <input type="checkbox"/> Maintenance Dose: 5mg/kg (_____ mg) IV every 8 weeks		
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg ER Tablet <input type="checkbox"/> 30 mg ER Tablet	<input type="checkbox"/> Take one tablet by mouth once daily <input type="checkbox"/> Take one tablet by mouth once daily <i>(For patients 12-65 yo with inadequate response to 15 mg QD & who are not taking strong CYP3A4 inhibitors and do not have severe renal impairment)</i>	30 30	
<input type="checkbox"/> Siliq*	<input type="checkbox"/> 210mg PFS	<input type="checkbox"/> Load: Inject 210mg subcutaneously on weeks 0, 1, and 2, then every 2 weeks thereafter <input type="checkbox"/> Maintenance: Inject 210mg subcutaneously every 2 weeks		
<input type="checkbox"/> Simponi*	50mg <input type="checkbox"/> SmartJect* <input type="checkbox"/> PFS	Inject 50mg subcutaneously once a month as directed		
<input type="checkbox"/> Skyrizi™	150mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Starter: Inject 150mg subcutaneously on week 0 <input type="checkbox"/> Maintenance: Inject 150mg subcutaneously on week 4, then every 12 weeks thereafter		
<input type="checkbox"/> Stelara*	<input type="checkbox"/> 45mg PFS (Weight ≤100kg) <input type="checkbox"/> 90mg PFS (Weight >100kg) <input type="checkbox"/> 45mg Vial (For Adol: <60kg)	<input type="checkbox"/> Starter: Inject 1 syringe subcutaneously on week 0 <input type="checkbox"/> Maintenance: Inject 1 syringe subcutaneously on week 4, and then every 12 weeks thereafter <input type="checkbox"/> Starter: Inject _____ mg (0.75mg/kg) subcutaneously on week 0 <input type="checkbox"/> Maintenance: Inject _____ mg (0.75mg/kg) subcutaneously on week 4, then every 12 weeks thereafter		
<input type="checkbox"/> Taltz*	80mg <input type="checkbox"/> Autoinjector <input type="checkbox"/> PFS	<input type="checkbox"/> Load (Plaque psoriasis): Inject 160mg (as two-80mg injections) subcutaneously on week 0, then 80mg on week 2, then Inject 80mg subcutaneously every 2 weeks (weeks 4-10), then Inject 80mg subcutaneously at week 12 <input type="checkbox"/> Load (Psoriatic arthritis): Inject 160mg (as two-80mg injections) subcutaneously on week 0 <input type="checkbox"/> Maintenance: Inject 80mg subcutaneously every 4 weeks		
<input type="checkbox"/> Tremfya*	100mg <input type="checkbox"/> One-Press Injector <input type="checkbox"/> PFS	<input type="checkbox"/> Starter: Inject 100mg subcutaneously on week 0 <input type="checkbox"/> Maintenance: Inject 100mg subcutaneously on week 4, then every 8 weeks thereafter		

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must <i>handwrite</i>)	

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DERMATOLOGY REFERRAL FORM (U-Z)

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email		Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

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CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment		Therapy Start Date			
Sample/Starter Product Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Provide Qty:		Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No		TB Test Results		Test Date	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Latex <input type="checkbox"/> Drug Allergies (please list)			<input type="checkbox"/> Other (please list)		
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted	
ICD-10 Codes <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified <input type="checkbox"/> L40.0 Psoriasis vulgaris <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> L73.2 Hidradenitis, suppurativa <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> Date of Diagnosis _____					

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg Tablet <input type="checkbox"/> 11mg XR Tablet	<input type="checkbox"/> Take one 5mg tablet PO twice daily <input type="checkbox"/> Take one 11mg tablet PO once daily		
<input type="checkbox"/> Zoryve 0.3% Cream (3 mg roflumilast/gm)	<input type="checkbox"/> 60 gm Tube	<input type="checkbox"/> Apply to affected area(s) once daily <input type="checkbox"/> Other: _____ Involved area(s) of skin: _____		
<input type="checkbox"/> Other _____				
<input type="checkbox"/> Other _____				
<input type="checkbox"/> Other _____				

Prescriber Signature

Date

Supervising Physician Signature (where required by state law)

Date

DAW (Dispense as Written)

Date

Brand Necessary (must *handwrite*)

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