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.

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PATIENT INFORM	MATION														
Last Name	Name First Name			В		Gender 🗆	м□F	F Last 4 SSN			Primary Language				
Address				С				State			ZIF	•			
Email		Hor	ne Phone			Work	Phone		Cell Phone						
Primary Contact Meth	od (check one)	☐ Cell Phone	☐ Home Phone	□Work	Phone 🗆 🗆	ext □ Ema	I □ P	rimary Caregiver		о пот с	ONTACT				
Primary Caregiver/Alt	Contact Name (I	f applicable)		Alt (Contact Ema	nil				А	It Contact Pho	one			
PRESCRIBER INF	ORMATION														
Name of Contact Send	ding Referral			Title			Pre	ferred Contact Me	thod (c	heck one	e) 🗆 Email	☐ Phone	□ Fax		
Referral Contact Email	1					Office Pho	ne			Office	Fax				
Practice / Facility Nam	ne					Prescriber	Name /	Specialty							
Address						City					State	ZIP			
Prescriber State Licen				NPI#				Medicai	d UPIN #						
		* Plea	se include a d	сору о	f the fro	nt and ba	ck of	insurance c	ard *						
CLINICAL INFOR	MATION - Pl	ease include	applicable clir	nical ch	art notes										
Prescription Type								Therapy Start Da	te						
Sample/Starter Produc					1	ole Provided									
If Self-injectable drug,				armacy?				TB Test Results			Test Date				
Other/Concomitant Me															
		ug Allergies (plea	ase list)				□ Other	(please list)							
Ship to Address			Other (please list)	-				(1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-							
Patient Height (cm/in)		Patient Weight (I		Date O	btained		%	BSA impacted			BSA Areas i	mpacted			
Patient Height (cm/in) Patient Weight (kg/lbs) Date Obtained % BSA impacted BS ICD-10 Codes L20.9 Atopic dermatitis, unspecified L40.0 Psoriasis vulgaris L40.50 Arthropathic psoriasis, unspecified L73.2 Hidradenitis,															
	3.1 Prurigo nodula		☐ Other					ate of Diagnosis		_	, , , , , , , , , , , , , , , , , , , ,				
PRESCRIPTION II															
In order for a brand or your state-specifi															
MEDICATION	DOSE		DIRECTIONS									QTY	REFILLS		
□ Adbry	☐ 150 mg/ml Pl	FS	Initial Dose:												
•	3,			☐ Inject 600 mg (4x150 mg injections) SC on Day 1, followed by 300 mg (2x150 mg injections) SC o Day 15											
				Note: Multiple injections to be administered at different injection sites within the same body area Maintenance Dose:											
			☐ Inject 300	☐ Inject 300 mg (2x150 mg injections) SC every other week.											
				☐ 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)											
			Note: Multip	Note: Multiple injections to be administered at different injection sites within the same body area											
☐ Cibinqo	☐ 50 mg Tablet	 :						food, at the same							
	□ 100 mg Table	et										30			
☐ Cimzia*	□ 200mg x2 PF		□ (PsO) Inje	☐ (PsO) Inject 400mg (as two-200mg injections) subcutaneously every other week											
	□ 200mg x2 Vi		☐ (PsO) Alte	ernate loa	ad (pt ≤90kg): Inject 400n	ng (as tv	wo-200mg injection	ns) at	weeks 0,					
			☐ (PsA) Star	☐ (PsO) Alternate maintenance (pt ≤90kg): Inject 200mg subcutaneously every other week ☐ (PsA) Starter Kit: Inject 400mg (as two-200mg injections) subcutaneously at weeks 0, 2, and 4 ☐ (PsA) Maintenance: Inject 400mg subcutaneously every 4 weeks											
						ng subcutane ng subcutane									
☐ Cosentyx*	300mg (2x150r	mg) 🗆 Pen 🗆 PFS	□ Load: Inje	ct 300mg	g subcutane	ously on week	0, 1, 2,	3							
	150mg □ Pen □	PFS		☐ Maintenance: Inject 300mg subcutaneously on week 4, then every 4 weeks thereafter ☐ Load: Inject 150mg subcutaneously on week 0, 1, 2, 3											
								4, then every 4 we	eks the	ereafter					
☐ Dupixent*	300mg 🗆 Pen 🗆	☐ PFS w/Shield		□ Load: Inject 600mg (as two-300mg injections in different sites) on day 1, then inject 300mg											
				every other week starting on day 15 Maintenance: Inject 300mg subcutaneously every other week											
	200mg □ Pen □	en PFS w/Shield								00mg					
						ay 15 ocutaneously (every ot	her week							
	1		I									1	1		
			_												
Prescriber Signature			Date			Supervising I	nysiciai	n Signature (where	erequir	ed by sta	ite law) l	Date			
DAW (Dispense as Written)			Date			Brand Neces									

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

DERMATOLOGY REFERRAL FORM (E-O)

PHONE 888.370.1724 | **FAX** 877.645.7514



remove e	above portion k	octore rax	irig. i icus	ic complete	the pres	cription	, , , , , , , ,	iii its entire	cy arr	u rax witii secu	ii c covei	Sincel	.o the ma	iiiibci abov					
PATIENT INFORM	IATION																		
Last Name		First Nam	е	DO	В		G	ender 🗆 M	□F	Last 4 SSN	rimary Language								
Address						С	City				State		- 2	ZIP					
Email			Home Ph	one		•		Work Pho	Cell Phon	,									
Primary Contact Meth	od (check one)	☐ Cell Pho	ne 🗆 H	ome Phone	□ Work I	Phone	☐ Text	☐ Email	□ Pri	imary Caregiver	□ DO 1	чот со	NTACT						
Primary Caregiver/Alt	Contact Name (I	f applicable	:)		Alt (Contact E	Email					Alt	Contact F	Phone					
PRESCRIBER INF	ORMATION																		
Name of Contact Send	ling Referral				Title				Prefe	erred Contact Me	ethod (che	ck one)	□ Emai	il 🗆 Phone	☐ Phone ☐ Fax				
Referral Contact Emai	l							Office Phone				Office F	ax						
Practice / Facility Nam	пе							Prescriber Na											
Address						City	1			tate	Z	IP .							
Prescriber State Licen	A #				NPI	#			M	ledicaid	UPIN#								
* Please include a copy of the front and back of insurance card *																			
CLINICAL INFOR	MATION - Ple	ease incl	ude app	licable cli	nical ch	art not	tes												
Prescription Type 🗆 🗅	Naïve/New Start	☐ Therap	y Restart	☐ Existing T	reatment					Therapy Start Da	te								
Sample/Starter Produ	ct Provided?	es □ No I	f yes, Provi	de Qty:		Date S	ample I	Provided											
If Self-injectable drug,	is injection train	ing coordin	ation requ	ired by our pl	harmacy?	☐ Yes	□No		Τ.	TB Test Results			Test Da	te					
Other/Concomitant Me	edications (pleas	e list)																	
Allergies □ NKDA	□ Latex □ Dru	g Allergies	(please lis	t)					Other	(please list)									
Ship to Address 🗆 H	ome 🗆 Prescri	ber's Office	□ Othe	r (please list)															
Patient Height (cm/in)) F	Patient Wei	ght (kg/lbs	5)	Date O	otained			% В	BSA Area	Areas impacted								
ICD-10 Codes											rativa	ra .							
PRESCRIPTION II	NFORMATIO	N - Pleas	e Escrib	e if requir	ed by st	tate la	w												
n order for a brand or your state-specifi	name product	to be disp	pensed, th	he prescribe	er must h	andwrit	te "Bra t a vali	nd Necessa	ry" oi	r "Brand Medic rm for writing	ally Nece	essary,"	ications						
MEDICATION	DOSE	juage to p	nornon st	DIRECTION		11 13 1100	t a vali	u prescripti	OH IO.	illi for writing t	CONTRONE	u meui	cations.	QTY	REFILLS				
☐ Enbrel*		lick Auto-In	iector	□ Load: Inject 50mg subcutaneously twice a week, 72-96 hours apart x3 months											REFILES				
_ Elibrei	□ 50 mg SureClick Auto-Injector □ 50 mg PFS □ 50 mg Mini Cartridge □ 25 mg PFS □ 25 mg SDV			☐ Maintenance: Inject 50mg subcutaneously once a week ☐ Other:															
				Pediatric W	/eight:		Date	Taken:		-									
□ Eucrisa	2% Ointment ☐ 60gm ☐ 100gm			☐ Apply a thin layer to affected area(s) twice daily															
□ Humira CF (Plaque Psoriasis)	☐ Starter Pack (40 mg/0.4 mL l		g/0.8 mL,	Initial Dose		day 1, fo	ollowed	by 40 mg S0	C on D	ay 8 & Day 22				1 Starte Pack					
	□ 40 mg/0.4 m □ 40 mg/0.4 m			Maintenanc □ Inject 40 □ Other:		ery othe	r week.												
□ Humira CF (Hidradenitis Suppurativa)	☐ Starter Pack (PENS	(CF): 80 mg	g/0.8 mL	☐ Inject 160	Initial Dose: ☐ Inject 160mg (2 x 80 mg) SC on Day 1, then 80mg SC two weeks later (on Day 15). ☐ Inject 80 mg SC on Day 1, 80 mg SC on Day 2, then 80 mg SC two weeks later (on Day 15).										er				
	☐ 40 mg/0.4 m ☐ 40 mg/0.4 m ☐ 80 mg/0.8 m	L (CF) PFS		Maintenance Dose: ☐ Inject 40 mg SC on Day 29 and every week thereafter. ☐ Inject 80 mg SC on Day 29 and every other week thereafter.															
☐ Humira CF (Psoriatic Arthritis)	□ 40 mg/0.4 m □ 40 mg/0.4 m			Maintenanc		ery other	week.	-											
□ Ilumya	□ 100mg/ml PF	:s		□ Inject 100	Omg at We	eks 0,4,	and ev	ery 12 weeks	therea	after									
□ Opzelura	☐ 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.										ot					
□ Orencia	☐ 250mg Vial ☐ 125mg PFS ☐ 125mg Clickje	et Pen		Inject 125m	g Subcuta	neously	once w	reekly											
□ Otezla*	☐ Starter Pack ☐ 30mg Tablet			□ Take 1 tak				aily as directe	ed										
rescriber Signature				Date			Su	pervising Phy	sician	Signature (where	e required	by stat	e law)	Date					
AW (Dispense as Writ	ten)			Date			Bra	and Necessar	y (mus	st handwrite)									

DAW (Dispense as Written) Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

DERMATOLOGY REFERRAL FORM (P-T)

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.

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PATIENT INFORM	1ATION								ı							
Last Name		First Name	DC	DOB			□ M □	☐ F Last 4 SSN			Pi	Primary Language				
Address					City					State			ZIP			
Email		Hom	ne Phone			Wor	k Phone	е				Cell Pho	one			
Primary Contact Meth	od (check one)	☐ Cell Phone	☐ Home Phone	☐ Work Phone	□ Tex	xt 🗆 En	nail [□ Pri	mary Caregiver	□ DO	NOT CO	ONTACT				
Primary Caregiver/Alt	Contact Name (If	applicable)		Alt Contac	ct Email						Α	It Contact	t Phone			
PRESCRIBER INF	ORMATION															
Name of Contact Send	ding Referral			Title			F	Prefe	erred Contact Met	hod (ch	neck one	e) 🗆 Em	nail 🗆 Pho	ne l	□Fax	
Referral Contact Emai	I					Office P	hone				Office	Fax				
Practice / Facility Nan	ne					Prescrib	er Nam	ne / S	Specialty							
Address					Ci	ity						State		ZIP		
Prescriber State Licen	se #	DEA #			N	PI#					Medicai	d UPIN #				
		* Pleas	se include a	copy of the	e fron	it and l	back	of i	insurance ca	ard *						
CLINICAL INFOR	MATION - Ple	ease include	applicable cli	inical chart n	otes											
Prescription Type 🗆 l	Naïve/New Start	☐ Therapy Res	tart 🗆 Existing	Treatment				7	Therapy Start Dat	е						
Sample/Starter Produ	ct Provided? 🗆 Y	es 🗆 No If yes,	Provide Qty:	Date	Sample	e Provide	d									
If Self-injectable drug,	, is injection traini	ng coordination	required by our p	harmacy? 🗆 Ye	es 🗆 No)		1	ΓB Test Results			Test D	ate			
Other/Concomitant M	edications (pleas	e list)										'				
Allergies	□ Latex □ Dru	g Allergies (plea	se list)				□ Otl	her ((please list)							
Ship to Address ☐ H	ome 🗆 Prescril	per's Office	Other (please list))												
Patient Height (cm/in)) P	atient Weight (k	g/lbs)	Date Obtaine	ed				SA impacted		BSA Are					
	0.9 Atopic dermat 3.1 Prurigo nodula		☐ L40.0 Psoria	sis vulgaris 🗆 l	L40.50 /	Arthropat			s, unspecified te of Diagnosis _		lidraden –	itis, supp	urativa			
PRESCRIPTION II	NFORMATION	N - Please Es	cribe if requi	red by state	law											
In order for a brand	name product	to be dispense	ed, the prescribe	er must handw	rite "Bi											
or your state-specifi		luage to promi			IOL a Vo	alia preso	riptioi	1101	m for writing c	Ontroll	ea med	aications			DEE: 10	
MEDICATION	DOSE		DIRECTION			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							QTY		REFILLS	
☐ Remicade ☐ Inflectra ☐ Renflexis ☐ Avsola	□ Vial (weight b	oased)		lose: 5mg/kg (ance Dose: 5mg/		_ mg) IV a m										
□ Rinvoq	☐ 15 mg ER Tab	let	☐ Take one	tablet by mouth	n once d	laily							3	0		
	□ 30 mg ER Tab	olet	(For patier	☐ Take one tablet by mouth once daily (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)									3	0		
☐ Siliq*	□ 210mg PFS			ect 210mg subcu ance: Inject 210m					2, then every 2 weeks	eeks th	ereafter					
☐ Simponi*	50mg □ SmartJ	ect* 🗆 PFS	Inject 50m	g subcutaneousl	ly once a	a month a	s direct	ed								
□ Skyrizi™	150mg □ Pen □	PFS		nject 150mg sub ance: Inject 150m												
□ Stelara*	□ Maintenance: Inject 150mg subcutaneously on week 4, then every 12 weeks thereafter □ 45mg PFS (Weight ≤100kg) □ 90mg PFS (Weight >100kg) □ 45mg Vial (For Adol: <60kg) □ 45mg Vial (For Adol: <60kg) □ Maintenance: Inject 1 syringe subcutaneously on week 4, and then every 12 weeks thereafter □ 5tarter: Inject mg (0.75mg/kg) subcutaneously on week 0 □ Maintenance: Inject mg (0.75mg/kg) subcutaneously on week 4, then every 12 weeks thereafter															
□ Taltz*	80mg □ Autoin □ PFS	□ 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 □ Load (Psoriatic arthritis): Inject 160mg (as two-80mg injections) subcutaneously on week 0 □ Maintenance: Inject 80mg subcutaneously every 4 weeks														
□ Tremfya®	100mg □ One-I □ PFS	One-Press Injector Starter: Inject 100mg subcutaneously on week 0 PFS Maintenance: Inject 100mg subcutaneously on week 4, then every 8 weeks thereafter														
Prescriber Signature			Date		_				Signature (where	require	ed by sta	nte law)	Date			
DAW (Dispense as Writ	ten)		Date		В	Brand Nec	essary ((mus	t handwrite)							

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DERMATOLOGY REFERRAL FORM (U-Z)

PHONE 888.370.1724 | **FAX** 877.645.7514



Remove	above portion l	before fax	ing. Please	comple	ete the pres	scription f	orm	in its entire	ty and	d fax with sec	ure co	er she	et to the i	number a	bove.		
PATIENT INFORM	NOITAN																
Last Name		First Nam	e	DOB				ender 🗆 M	□F	Last 4 SSN		Pi		Primary Language			
Address			City	у					State ZI			ZIP					
Email			Home Phor	ne				Work Pho	ne				Cell Ph	one			
Primary Contact Meth	od (check one)	☐ Cell Pho	one 🗆 Hon	ne Phon	e 🗆 Work	Phone \square	Text	☐ Email	□ Pri	imary Caregiver	- D	о пот	CONTACT				
Primary Caregiver/Alt	Contact Name (I	f applicable	e)		Alt	Contact En	nail						Alt Contac	t Phone			
PRESCRIBER INF	ORMATION																
Name of Contact Send	ding Referral				Title				Prefe	erred Contact M	lethod (check o	ne) 🗆 En	nail 🗆 Ph	one	□ Fax	
Referral Contact Emai	il							Office Phone				Offic	ce Fax				
Practice / Facility Nar	ne							Prescriber Na	me / s	Specialty							
Address							City	/					State		ZIP		
Prescriber State Licen	ise #	DE	EA #				NP	#				Medic	aid UPIN #				
		* <i>F</i>	Please inc	clude	а сору о	of the fr	ont	and back	cof	insurance (card [•]						
CLINICAL INFOR	MATION - Ple	ease incl	ude appli	cable	clinical ch	art note	s										
Prescription Type	Naïve/New Start	☐ Therap	y Restart [□ Existin	g Treatment	:				Therapy Start D	ate						
Sample/Starter Produ	ct Provided? 🗆 Y	∕es □ No I	f yes, Provide	e Qty:		Date San	nple	Provided									
If Self-injectable drug	☐ Yes ☐	No		-	TB Test Results			Test [Date								
Other/Concomitant M	edications (pleas	e list)															
Allergies □ NKDA	□ Latex □ Dru	ug Allergies	(please list)						Other ((please list)							
Ship to Address ☐ H	lome 🗆 Prescri	ber's Office	e □ Other (please l	ist)												
Patient Height (cm/in) Patient Weight (kg/lbs) Date Obtained % BSA impacted BSA Areas in												eas impact	ed				
ICD-10 Codes ☐ L20	0.9 Atopic derma 3.1 Prurigo nodula			10.0 Pso ther	riasis vulgari	is 🗆 L40.	50 Aı	rthropathic ps		s, unspecified Ite of Diagnosis		Hidrad —	enitis, supp	ourativa			
PRESCRIPTION I In order for a brand	name product	to be disp	pensed, the	prescr	iber must h	nandwrite	"Bra										
or your state-specif		guage to p				rm is not a	vali	id prescripti	on fo	rm for writing	contro	olled m	edication.				
MEDICATION	DOSE			DIRECTI										QTY		REFILLS	
□ Xeljanz	☐ 5mg Tablet ☐ 11mg XR Table	et			one 5mg tabl one 11mg tabl												
☐ Zoryve 0.3% Cream	☐ 60 gm Tube			☐ Apply to affected area(s) once daily ☐ Other:													
(3 mg roflumilast/gm)				Involved area(s) of skin:													
☐ Other																	
☐ Other																	
□ Other																	
Prescriber Signature				Date				pervising Phy	sician	Signature (whe	re requi	red by s	state law)	Date			
DAW (Dispense as Written)				Date			Brand Necessary (must handwrite)										

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