DERMATOLOGY REFERRAL FORM (A-C)

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 INFORM	MATION												
Last Name		First Name	DC	В		Gender \square	M □F	Last 4 SSN	,	Prima	ary Languag	е	
Address					City				State		ZIP		
Email		Hom	e Phone			Work	Phone			Ce	ell Phone		
Primary Contact Meth	od (check one)	☐ Cell Phone	☐ Home Phone	☐ Work Phone	□ Te	xt 🗆 Ema	il 🗆 F	Primary Caregiver	□ DO N	IOT CONT	TACT		
Primary Caregiver/Alt	Contact Name (I	f applicable)		Alt Conta	ct Email					Alt Co	ontact Phon	e	
PRESCRIBER INF	ORMATION									<u>.</u>			
Name of Contact Send	ding Referral			Title			Pre	eferred Contact Me	ethod (che	ck one)	□ Email [☐ Phone	□Fax
Referral Contact Emai	il					Office Pho	ne		(Office Fax	(
Practice / Facility Nan	ne					Prescriber	Name ,	/ Specialty					
Address					Ci	ity				Sta	ite	ZIP	
Prescriber State Licen	ise #	DEA #				PI#				edicaid UI	PIN#		
		* Pleas	e include a	copy of the	e fron	t and ba	ick o	f insurance c	ard *				
CLINICAL INFOR	MATION - Ple	ease include a	applicable cli	nical chart n	otes								
Prescription Type 🗆 I	Naïve/New Start	☐ Therapy Rest	art 🗆 Existing	Treatment				Therapy Start Da	te				
Sample/Starter Produ	ct Provided? 🗆 Y	es 🗆 No If yes, F	Provide Qty:	Date	e Sample	e Provided							
If Self-injectable drug	, is injection train	ing coordination i	equired by our p	harmacy? 🗆 Ye	es 🗆 No)		TB Test Results			Test Date		
Other/Concomitant M	edications (pleas	e list)											
Allergies □ NKDA	☐ Latex ☐ Dru	g Allergies (pleas	se list)				☐ Othe	r (please list)					
Ship to Address ☐ H	ome 🗆 Prescri	ber's Office 🗆 🔾	Other (please list))									
Patient Height (cm/in) F	Patient Weight (kg	g/lbs)	Date Obtaine	ed		%	BSA impacted		BS	SA Areas im	pacted	
	0.9 Atopic dermat 3.1 Prurigo nodula		☐ L40.0 Psoria ☐ Other	sis vulgaris 🔲	L40.50	Arthropathio		sis, unspecified [Date of Diagnosis		Iradenitis,	, suppurativa	ì	
PRESCRIPTION II	NFORMATIOI	N - Please Esc	cribe if requi	red by state	law								
In order for a brand or your state-specifi											ations		
MEDICATION	DOSE	juage to promo	DIRECTION		iot a ve	illa prescri	ριιστι	om for writing	controlled	a medice	ations.	QTY	REFILLS
□ Adbry	☐ 150 mg/ml PF	e e	Initial Dose									GII	REFIELS
□ Adbiy	130 mg/mi PP	-3			g injectio	ons) SC on [Day 1, fo	llowed by 300 mg	(2x150 mg	g injectior	ns) SC on	6	
			Note: Multi	ple injections to	be adm	inistered at	differer	nt injection sites w	ithin the sa	me body	area		
			☐ Inject 30	0 mg (2x150 mg	injectio	ons) SC ever	y 4 wee	week. ks (body weight <	100 kg & h	nave achie	eved clear	28-day	
			Note: Multi	ple injections to	be adm	inistered at	differer	nt injection sites w	ithin the sa	me body	area		
☐ Bimzelx	☐ 160mg/ml Au	tolnjector	Initial Dose):									
	☐ 160mg/ml Sy	ringe	□ 320mg (2x160mg) SC or	ice ever	y 4 weeks fo	r 16 we	eks					
			Maintenand	ce Dose: 2x160mg) SC on	ca avar	v 8 weeks						2	
			_ 520mg (zxioomg, sc or	ice ever	y o weeks							
□ Cibinqo	☐ 50 mg Tablet☐ 100 mg Table☐ 200 mg Table☐ 200 mg Table☐ 200 mg Table	t	☐ Take one	tablet by moutl	n once d	laily, with or	withou	t food, at the same	e time each	n day.		30	
□ Cimzia*	□ 200mg x2 PF □ 200mg x2 Via		☐ (PsO) Alt☐ (PsO) Alt☐ (PsA) Sta☐ (PsA) Ma	ternate load (pt ternate maintena	≤90kg): ance (pt 100mg (t 400mg	Inject 400r ≤90kg): Inje as two-200 g subcutane	ng (as t ect 200 mg inje ously e		ons) at wee y every oth	eks 0, 2, a her week			
□ Cosentyx*	300mg (2x150n 150mg □ Pen □	ng) 🗆 Pen 🗆 PFS PFS	☐ Maintena ☐ Load: Inj	ect 150mg subc	ng subc utaneou	utaneously sly on week	on week 0, 1, 2, 3	4, then every 4 w					
Prescriber Signature			Date		-	unarvising !	Ohysicia	n Signature (wher	e required	by state	aw) D	ate	
riescriber signature					_				e required	by state I		ite	
DAW (Dispense as Writ	ten)		Date		В	Brand Neces	sary (m	ust handwrite)					

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 (D-I)

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 INFORM	IATION															
Last Name		First Name		DO	В		(Gender □ M	□F	Last 4 SSN		Pri	mary La	anguage	9	
Address							City				State			ZIP		
Email		ŀ	Home Phone	е				Work Ph	one				Cell Ph	none		
Primary Contact Meth	od (check one)	☐ Cell Phone	e 🗆 Hom	ne Phone	□ Work	Phone	☐ Text	t 🗆 Email	□Р	Primary Caregiver	□ DO 1	чот со	NTACT			
Primary Caregiver/Alt	Contact Name (If	applicable)			Alt	Contact	t Email					Alt	Contac	ct Phone	9	
PRESCRIBER INF	ORMATION															
Name of Contact Send	ling Referral				Title				Pre	eferred Contact Me	thod (che	ck one)	□Eı	mail [] Phone	□ Fax
Referral Contact Emai	I							Office Phone	Э			Office F	ax			
Practice / Facility Nam	ne							Prescriber N	ame /	/ Specialty						
Address							Cit	у				S	State		ZIP	
Prescriber State Licen	se #	DEA	#				NP	1#			М	ledicaid	UPIN #	#	'	
		* Ple	ease inc	lude a d	сору о	f the	front	and bac	k of	finsurance c	ard *					
CLINICAL INFOR	MATION - Ple															
Prescription Type 🗆 N										Therapy Start Da	te					
Sample/Starter Produc					Teatment	1	Sample	Provided		merapy start ba						
If Self-injectable drug,					narmacy?			TTOVIACA		TB Test Results			Test	Date		
Other/Concomitant Me			ion required	a by our pr	idilliacy.		110			TD Test Results			1630	Date		
Allergies		-	olease list)					П	Other	r (please list)						
Ship to Address		per's Office		nlease list)						. (p.odocot)						
Patient Height (cm/in)		atient Weigh		picase listy	Date O	htained	4		%	BSA impacted			ΒSΔ Δ	reas im	nacted	
ICD-10 Codes □ L20				0.0 Psorias		-		rthropathic p		sis, unspecified	L73.2 Hi					
	.1 Prurigo nodula		□Ot							Date of Diagnosis			,,.			
PRESCRIPTION I										" "						
n order for a brand or your state-specifi														ns.		
MEDICATION	DOSE			DIRECTION											QTY	REFILLS
□ Dupixent*	300mg □ Pen □	PFS w/Shiel	d [☐ Load: Inje	ect 600mg	g (as tw	vo-300n	ng injections	in diff	ferent sites) on day	y 1, then ir	nject 30	0mg			
				ner week s nce: Inject			15 taneously ev	ery ot	her week							
	200mg □ Pen □	PFS w/Shiel	PFS w/Shield							y 1, then ir	nject 20	0mg				
	_	-	every other week starting on day 15 Maintenance: Inject 200mg subcutaneously every other week													
□ Enbrel®	☐ 50 mg SureCl	ick Auto-Inie									months					
	☐ 50 mg PFS			☐ Load: Inject 50mg subcutaneously twice a week, 72-96 hours apart x3 months ☐ Maintenance: Inject 50mg subcutaneously once a week ☐ Other:												
☐ 25 mg PFS				Pediatric Weight: Date Taken:												
7 Formula	□ 25 mg SDV			Apply a thin layer to affected area(s) twice daily												
□ Eucrisa	2% Ointment ☐ 60gm			J Appiy a ti	nın layer t	о аттес	tea area	i(s) twice dai	ıy							
	□ 100gm															
□ Humira CF (Plaque Psoriasis)	☐ Starter Pack (40 mg/0.4 mL F			nitial Dose: ∃Inject 80		day 1,	followed	d by 40 mg S	C on [Day 8 & Day 22					1 Starter Pack	
	□ 40 mg/0.4 ml			Maintenanc												
	☐ 40 mg/0.4 ml	L PEN (CF)		☐ Inject 40 ☐ Other:	mg SC ev	ery oth	er week	ζ.								
☐ Humira CF	☐ Starter Pack (CF): 80 mg/(nitial Dose:											1 Starter	
(Hidradenitis Suppurativa)	PENS									C two weeks later of two weeks			5)		Pack	
ouppuruvu)	□ 40 mg/0.4 ml	L (CE) PEN		Maintenanc								,,, , , , , , , , , , , , , , , , , ,	-			
	☐ 40 mg/0.4 m	L (CF) PFS		☐ Inject 40	mg SC or			ery week the								
□ Humaina CE	□ 80 mg/0.8 ml					Day 29	and ev	ery other we	ek tne	erearter.						
□ Humira CF (Psoriatic Arthritis)	□ 40 mg/0.4 ml			Maintenanc □ Inject 40:	mg SC eve	ery othe	er week.									
□ Humania	□100·········/ 1.5=	<u> </u>		Other:			1		- -							
□ Ilumya	□ 100mg/ml PF	s 		⊔ inject 100	mg at We	eeks 0,4	4, and e	very 12 weeks	tnere	earter						
rescriber Signature				Date			Su	pervising Ph	ysiciar	n Signature (where	e required	by stat	e law)	Da	te	
							_									

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

Brand Necessary (must handwrite)

DERMATOLOGY REFERRAL FORM (J-S)

PHONE 888.370.1724 | **FAX** 877.645.7514



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	•		•										
PATIENT INFORM	MATION												
Last Name		First Name	DC	ОВ		Gender [M DF	Last 4 SSN		Pri	mary Langu	age	
Address				,	City				State		ZII	Р	
Email		Hon	ne Phone			Work	Phone				Cell Phone		
Primary Contact Meth	nod (check one)	☐ Cell Phone	☐ Home Phone	☐ Work Phone	e □ Te	xt 🗆 Ema	ail 🗆 I	Primary Caregiver	DO	иот со	NTACT		
Primary Caregiver/Alt	Contact Name (If	applicable)		Alt Conta	ct Email					Alt	Contact Ph	one	
PRESCRIBER INF	FORMATION												
Name of Contact Sen	ding Referral			Title			Pre	eferred Contact M	lethod (ch	eck one)	☐ Email	☐ Phone	□ Fax
Referral Contact Emai	il					Office Ph	one			Office F	ах		
Practice / Facility Nar	ne					Prescribe	r Name	/ Specialty					
Address					С	ity				S	State	ZI	Р
Prescriber State Licen	nse #	DEA #			N	PI#			١	1edicaid	UPIN#		
		* Pleas	se include a	copy of the	e fron	it and b	ack o	f insurance (card *				
CLINICAL INFOR	RMATION - Ple	ease include	applicable cli	nical chart r	otes								
Prescription Type	Naïve/New Start	☐ Therapy Res	tart 🗆 Existing	Treatment				Therapy Start D	ate				
Sample/Starter Produ	ıct Provided? □ Y	es □ No If yes,	Provide Qty:	Date	e Sample	e Provided							
If Self-injectable drug	ı, is injection traini	ng coordination	required by our p	harmacy? 🗆 Ye	es 🗆 No)		TB Test Results			Test Date		
Other/Concomitant M	ledications (please	e list)											
Allergies □ NKDA	□ Latex □ Dru	g Allergies (plea	se list)				□ Othe	r (please list)					
Ship to Address ☐ H	lome 🗆 Prescril	per's Office	Other (please list))									
Patient Height (cm/in) P	atient Weight (k	g/lbs)	Date Obtaine	ed		%	BSA impacted			BSA Areas	impacted	
	0.9 Atopic dermat 8.1 Prurigo nodula	,	☐ L40.0 Psoria ☐ Other	sis vulgaris 🗆	L40.50	Arthropathi		sis, unspecified Date of Diagnosis		dradenit	tis, suppurat	iva	
PRESCRIPTION I	NFORMATION	N - Please Es	cribe if requi	red by state	law								
In order for a brand	l name product	to be dispense	ed, the prescribe	er must handw	vrite "B								
or your state-specif		luage to promi			iot a ve	aliu prescr	ιριιστι	ominor writing	CONTRONE	eu meui	ications.	OTV	DEFILLO
MEDICATION	DOSE		DIRECTION		:1	footoal over		ation area abouted		4 20% B	CA Damat	QTY	REFILLS
□ Opzelura	□ 1.5% Cream		use more t	han 60 grams (1	tube) p	er week. D		ation area should ue when signs/syr			SA. Do not		
□ Orencia	☐ 250mg Vial ☐ 125mg PFS ☐ 125mg Clickje	t Pen	Inject 125m	ng Subcutaneou:	sly once	weekly							
□ Otezla*	☐ Starter Pack ☐ 30mg Tablet			blet on day 1 the blet by mouth to			ected _						
□ Remicade	□ Vial (weight b	pased)		lose: 5mg/kg (_ ance Dose: 5mg/		_ mg) IV at mg)							
□ Rinvoq	☐ 15 mg ER Tab	let	☐ Take one	tablet by mout	h once d	laily						30	
	□ 30 mg ER Tab	olet	(For patier	tablet by mout ats 12-65 yo with and do not have	inadequ	uate respon		mg QD & who are	not taking	g strong	CYP3A4	30	
☐ Siliq*	☐ 210mg PFS			ect 210mg subcance: Inject 210m				nd 2, then every 2 weeks	weeks the	ereafter			
☐ Simponi*	50mg 🗆 SmartJ	ect* 🗆 PFS	Inject 50m	g subcutaneous	ly once	a month as	directed	I					
□ Skyrizi™	150mg □ Pen □	PFS		nject 150mg sub ance: Inject 150n				4, then every 12	weeks ther	eafter			
□ Stelara*	☐ 45mg PFS (W ☐ 90mg PFS (W ☐ 45mg Vial (Fo	/eight >100kg)	☐ Maintena ☐ Starter: I	nject nce: Inject	inge sub mg (0.	ocutaneousl 75mg/kg) s	y on we	ek 4, and then ever eously on week 0 ocutaneously on w)				
Prescriber Signature			Date		S	Supervising	Physicia	ın Signature (whe	re required	d by stat	e law)	Date	
DAW (Dispense as Writ	tten)		Date		E	Brand Neces	sary (m	ust handwrite)					

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DERMATOLOGY REFERRAL FORM (T-Z)

PHONE 888.370.1724 | **FAX** 877.645.7514



Remove	above portion before											
PATIENT INFORM	MATION											
Last Name	First I	Name	DOB		Gender □ M	□F	Last 4 SSN		Pri	mary Lang	uage	
Address	•			City				State	,	z	IP.	
Email		Home Pho	one	,	Work Pho	one				Cell Phone	9	
Primary Contact Meth	od (check one) Cell	I Phone □ Ho	ome Phone	Phone 🗆 T	Text □ Email	□ Pri	mary Caregiver	□ DO	NOT CO	NTACT		
Primary Caregiver/Alt	Contact Name (If applic	able)	Alt	Contact Ema	ail				Alt	Contact P	hone	
PRESCRIBER INF	ORMATION											
Name of Contact Send	ding Referral		Title			Prefe	erred Contact Me	thod (ch	eck one)	☐ Email	☐ Phone	□Fax
Referral Contact Emai	il		l.		Office Phone	:			Office F	ax		
Practice / Facility Nan	ne				Prescriber Na	ame / s	Specialty					
Address					City				S	State	ZIF	1
Prescriber State Licen	nse #	DEA #			NPI #				Medicaid	UPIN#		
		* Please in	iclude a copy o	f the fro	nt and bac	k of	insurance ca	ard *				
CLINICAL INFOR	MATION - Please i											
	Naïve/New Start □ Th					1.	Therapy Start Dat	· o				
	ict Provided? ☐ Yes ☐ N			1	ole Provided		Therapy Start Dai					
	, is injection training cod					Π.	TB Test Results			Test Date	Δ	
	ledications (please list)	Talliation requi	rea by our pharmacy.		10		TD Test Nesults			Test Date		
		gies (please list	<u> </u>		П	Other	(please list)					
Ship to Address						Other	piedse list)					
Patient Height (cm/in)		Weight (kg/lbs	-	btained		% P	SA impacted			BSA Aroas	simpacted	
	0.9 Atopic dermatitis, un		L40.0 Psoriasis vulgari) Arthropathic p			L73.2 H	idradenit		•	
□ L28	3.1 Prurigo nodularis		Other			□ Da	te of Diagnosis _					
	NFORMATION - PI						"D !!!	,, ,,				
	I name product to be ic required language											
MEDICATION	DOSE		DIRECTIONS								QTY	REFILLS
☐ Taltz*	80mg		☐ Load (Plaque psori									
	□ PFS		then 80mg on wee Inject 80mg subcu			taneou	sly every 2 weeks	(weeks	4-10), th	en		
			☐ Load (Psoriatic arthritis): Inject 160mg (as two-80mg injections) subcutaneously on week 0 ☐ Maintenance: Inject 80mg subcutaneously every 4 weeks									
☐ Tremfya*	100mg □ One-Press Ir	niector	☐ Starter: Inject 100n									
	□ PFS	ijectoi	☐ Maintenance: Inject				, then every 8 we	eks ther	eafter			
□ Xeljanz	☐ 5mg Tablet		☐ Take one 5mg table									
□ 7 -mus 0.79/	☐ 11mg XR Tablet		☐ Take 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		Supervising Phy	rsician	Signature (where	e require	d by stat		Date	

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