AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐Patient ☐Prescriber
☐Nursing needed; ☐Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

A-Hu BIOSIMILAR DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐M ☐F ☐Other:	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐**Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐L28.1 Prurigo nodularis ☐L40.0 Psoriasis ☐L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis ☐L40.59 ☐L50.1 Chronic Idiopathic Urticaria ☐L73.2 Hidradenitis Suppurativa ☐Other: _____

- Location: ☐Hands ☐Feet ☐Face ☐Scalp ☐Groin ☐Nails ☐Others: _____
- Severity: ☐Mild (up to 3% BSA) ☐Moderate (3-10% BSA) ☐Severe (*greater than* 10% BSA), BSA _____%

If treated previously for this condition, please indicate which drugs have been tried and failed: _____

Date range of previous therapy: _____

- Is patient currently on therapy? ☐Yes ☐No Type/ medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No, if yes, how long should patient wait before starting the new medication? _____
- Has patient received a PPD (tuberculosis) Skin Test? ☐Yes ☐No Results: _____
  Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

PRESCRIPTION INFORMATION

☐**STC Standard Protocol** will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and/or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Abrilada® ☐ 40mg/0.8ml pen OR ☐ 40mg/0.8ml syringe

☐ Starter dose for Hidradenitis Suppurativa: 160mg (4 x 40mg injections) SQ on day 1, then 80mg (2 x 40mg injections) SQ on day	QTY: 6 pens/syringes Refills: 0
☐ Maintenance dose for Hidradenitis Suppurativa: 40mg SQ every week (starting on day 29 from beginning of starter dose)	QTY: 4 pens/syringes Refills: 0
☐ Starter dose for Psoriasis: 80mg SQ as single dose, 7 day supply	QTY: 2 pens/syringes Refills: 0
☐ Maintenance dose for Psoriasis: 40mg SQ every other week (starting on day 8)	QTY: 2 pens/syringes Refills: ____

Amjevita® ☐ 40mg/0.8ml pen OR ☐ 40mg/0.8ml syringe

☐ Starter dose for Hidradenitis Suppurativa: 160mg (4 x 40mg injections) SQ on day 1, then 80mg (2 x 40mg injections) SQ on day 15	QTY: 6 pens/syringes Refills: 0
☐ Maintenance dose for Hidradenitis Suppurativa: 40mg SQ every week (starting on day 29 from beginning of starter dose)	QTY: 4 pens/syringes Refills: ____
☐ Starter dose for Psoriasis: 80mg SQ as a single dose, 7 day suppy	QTY: 2 pens/syringes Refills: 0
☐ Maintenance dose for Psoriasis: 40mg SQ every other week (starting on day 8 from beginning of starter dose)	QTY: 2 pens/syringes Refills: ____

Cyltezo® ☐ 40mg/0.8ml syringe

☐ Starter dose for Hidradenitis Suppurativa : 160mg (4 x 40mg injections) SQ on day 1, then 80mg (2 x 40mg injections) SQ on day 15	QTY: 6 syringes Refills: 0
☐ Maintenance dose for Hidradenitis Suppurativa : 40mg SQ every week (starting on day 29 from beginning of starter dose)	QTY: 4 syringes Refills: ___
☐ Starter dose for Psoriasis: 80mg SQ as single dose, 7 day suppy	QTY: 2 syringes Refills: 0
☐ Maintenance dose for Psoriasis: 40mg SQ every week (starting on day 8)	QTY: 4 syringes Refills: ___

Hadlima® ☐ 40mg/0.8ml pen OR ☐ 40mg/0.8ml syringe

☐ Starter dose for Hidradenitis Suppurativa: 160mg (4 x 40mg injections) SQ on day 1, then 80mg (2 x 40mg injections) SQ on day 15	QTY: 6 pens/syringes Refills: 0
☐ Maintenance dose for Hidradenitis Suppurativa: 40mg SQ every week (starting on day 29 from beginning of starter dose)	QTY: 4 pens/syringes Refills: ___
☐ Starter dose for Psoriasis: 80mg SQ as single dose, 7 day suppy	QTY: 2 pens/syringes Refills: 0
☐ Maintenance dose for Psoriasis: 40mg SQ every other week (starting on day 8)	QTY: 2 pens/syringes Refills: ___

Humira® ☐CF Pen Psoriasis Starter Kit NDC: 0074-1539-03 ☐Prefilled Syringe CF 40 mg/ 0.4 mL NDC: 0074-0243-02
*Pen Starter Kit will be dispensed if no preference indicated

☐Enroll in Humira Complete Program

☐Starter Dose for Psoriasis: ☐One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 (OR)	QTY: 3 pens Refills: 0
☐Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22	QTY: 4 syringes Refills: 0
☐Starter Dose not needed.	

Humira® ☐Starter Pkg CF 80 mg/0.8 mL Pen NDC: 0074-0124-03 ☐CF Prefilled Syringe 40 mg/0.4 mL NDC: 0074-0243-02
*Pen will be dispensed if no preference indicated

☐Starter Dose for Hidradenitis Suppurativa: ☐Inj 160 mg SQ day 1, then 80 mg SQ day 15 **(OR)**	QTY: 1 month Refills: 0
☐ Inj 80 mg SQ day 1, and 80 mg SQ day 2, then 80 mg SQ day 15	QTY: 1 month Refills: 0
☐Starter Dose not needed.	

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed.