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.

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: ☐L40.0 Psoriasis ☐L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis ☐L40.59 ☐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 _____%

☐L50.1 Chronic Idiopathic Uticaria

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).

☐**Cibinqo 50mg tablet** ☐ **Cibinqo 100mg tablet** ☐ **Cibinqo 200mg tablet**
☐1 tablet po once daily ☐Other _____ QTY: 1 month Refills: _____

☐**Cosentyx™ 150 mg/mL Sensoready® Pen** ☐**Cosentyx™ Prefilled Syringe 150 mg/mL** ☐**Cosentyx™ 150 mg Vial of Lyophilized powder**
**Sensoready® pen will be dispensed if no preference indicated*
☐Starter Dose: 300 mg SQ initially (Weeks 0, 1, 2, 3 and 4) then 300 mg SQ every 4 Weeks thereafter (Week 4) QTY: 5 weeks Refills: 0
☐Starter Dose not needed
☐Maintenance Dose: 300 mg SQ every 4 Weeks QTY: 1 month Refills: _____
☐Other _____

☐**Dupixent® (Dupilumab) 300 mg pen autoinjector** ☐**Dupixent® (Dupilumab) 300 mg prefilled syringe** **pen will be dispensed if no preference indicated*
☐Starter Dose: Inj. 600 mg SQ on Day 1, then 300 mg SQ every 2 Weeks starting on Day 15 QTY: QS for starter Refills: 0
☐Starter Dose not needed
☐Maintenance Dose: Inj. 300 mg (1 syringe) SQ every 2 Weeks QTY: 1 month Refills: _____

☐**Enbrel® 50 mg/ml SureClick** (autoinjector) ☐**Enbrel® 50 mg Prefilled Syringe** ☐**Enbrel® Mini 50 mg Cartridge** ☐**Enroll in Enliven® Program**
**SureClick will be dispensed if no preference indicated*
☐Starter Dose: 50 mg SQ twice weekly (72-96 hours apart) for 3 months QTY: 1 month Refills: 2
☐Starter Dose not needed
☐Maintenance Dose: 50 mg SQ weekly ☐Other _____ QTY: 1 month Refills: _____

☐**Enbrel® 25 mg/0.5 mL Prefilled Syringe** ☐ **Enbrel® 25 mg Single-Use Vial** **Prefilled Syringe will be dispensed if no preference indicated*
☐25 mg SQ twice weekly (72-96 hours apart) ☐Other _____ QTY: 1 month Refills: _____

☐**Erivedge® 150 mg Capsules** Take 1 Capsule Orally Once Daily QTY: 28 capsules Refills: _____

☐**Humira® CF Pen Psoriasis Starter Kit** *NDC: 0074-1539-03* ☐**Humira® Prefilled Syringe CF 40 mg/ 0.4 mL** *NDC: 0074-0243-02* ☐**Enroll in Humira Complete Program**
**Pen Starter Kit will be dispensed if not checked*
☐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® CF 40 mg/0.4 mL Pen** *NDC: 0074-0554-02* ☐**Humira® CF 40 mg/0.4 mL Syringe** *NDC: 0074-0243-02*
**pen will be dispensed if no preference indicated*
☐Maintenance Dose for Psoriasis: 40 mg SQ once every other week QTY: 1 month Refills: _____

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.

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DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION

☐**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐**Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

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☐**Humira® Starter Pkg CF 80 mg/0.8 mL Pen** *NDC: 0074-0124-03* ☐**Humira® 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)** ☐ Inj 80 mg SQ day 1, and 80 mg SQ day 2, then 80 mg SQ day 15 — QTY: 1 month / QTY: 1 month — Refills: 0 / Refills: 0
- ☐Starter Dose not needed.

☐**Humira® CF 40 mg/0.4 mL Pen** *NDC: 0074-0554-02* ☐**Humira® CF 40 mg/0.4 mL Syringe** *NDC: 0074-0243-02*

- ☐ Maintenance Dose for Hidradenitis Suppurativa: 40 mg SQ Day 29 and every week thereafter — QTY: 1 month — Refills:
- ☐ Other _____ — QTY: _____ — Refills:

☐**Ilumya™ 100 mg/mL Prefilled Syringes**

- ☐ Starter Dose: 100 mg SQ on Week 0 and Week 4 — QTY: 1 month (1 PFS) — Refills: 0
- ☐ Maintenance Dose: 100 mg SQ every 12 weeks (starting at week 4) — QTY: 1 syringe — Refills:

☐**Kevzara® (Sarilumab) pen autoinjector 200 mg/1.14 mL** ☐**Kevzara® (Sarilumab) prefilled syringe 200 mg/1.14 mL**
**Pens will be dispensed if no preference is indicated*

- ☐200 mg subcutaneously every 2 Weeks — QTY: 1 box (2) — Refills:

☐**Odomzo® 200 mg Capsule** PO Once Daily — QTY: 30 caps — Refills:

☐**Otezla® Tablets**

- ☐Titration Dose: Day 1: 10 mg in morning; Day 2: 10 mg in morning and 10 mg in evening; Day 3: 10 mg in morning and 20 mg in evening; Day 4: 0 mg in morning and 20 mg in evening; Day 5: 20 mg in morning and 30 mg in evening; Day 6 and thereafter: 30 mg twice daily — QTY: 1 month — Refills: 0
- ☐ Maintenance Dose: 30 mg twice daily — QTY: 60 tabs (30mg) — Refills:
- ☐ Other _____ — QTY: _____ — Refills:

☐**Remicade® 100 mg Vial** ☐**Inflectra® 100 mg Powder Vial** ☐**Renflexis® 100 mg Powder Vial** ☐ **Avsola® 100 mg Powder Vial** ☐**Enroll in AccessOneSM Program**
☐MD's Office Infusion ☐Home Infusion Supplies Required

- ☐ Starter Dose: _____ mg IV on Week 0, Week 2, Week 6, then _____ — QTY: QS 3 infusions — Refills: 0
- ☐ Maintenance Dose: _____mg IV every _____ Weeks — QTY: QS 1 infusions — Refills:

☐**Rinvoq 15mg tablet** ☐**Rinvoq 30mg tablet**

- ☐ 1 tablet po once daily — QTY: 1 month — Refills:

☐**Siliq® 210 mg/1.5 mL Prefilled Syringe (2 pack)** ☐**Enroll in REMS Program**

- ☐ Starter Dose for Plaque Psoriasis: 210 mg SQ at weeks 0, 1 and 2, followed by maintenance dose. — QTY: 1 box (2 PFS) — Refills: 0
- ☐ Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks. (starting at week 2) — QTY: 1 box (2 PFS) — Refills:

☐**Simponi® Aria 50 mg/4 mL** **Patient weight (kg):** _____ ☐**Enroll in SimponiOne® Program**

- ☐ Starter Dose: 2 mg/kg IV at weeks 0 and 4 — QTY: 1 month — Refills: 0
- ☐ Maintenance Dose: 2 mg/kg IV every 8 weeks — QTY: QS for 8 weeks — Refills:

☐**Simponi® SmartJect 50 mg/0.5 mL** ☐**Simponi® Prefilled Syringe 50 mg/0.5 mL** **Pens will be dispensed if no preference is indicated*

- ☐ 50 mg SQ every month — QTY: 1 month — Refills:
- ☐ Other: _____ — QTY: _____ — Refills:

☐**Skyrizi® Pen autoinjector 150mg/mL** ☐**Skyrizi® prefilled syringe 150mg/ml** **Pens will be dispensed if no preference is indicated*

- ☐ Starter dose: 150 mg SQ at Week 0 and 4 — QTY: 1 — Refills: 0
- ☐ Maintenance Dose: 150 mg SQ every 12 Weeks — QTY: 1 — Refills:

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

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Rev: 7.25.22

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An envolve Solution

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PATIENT INFORMATION			
Patient Name:		DOB:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION

☐**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐**Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

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☐**Stelara® Prefilled Syringe** ☐**Stelara® Vial** ☐MD's Office Infusion ☐Home Infusion Supplies Required ☐**Enroll in Janssen CarePath Program**

**Pre-filled syringe will be dispensed if preference is not indicated*

☐≤ 100 kg Starter Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 Weeks of initial dose (week 4)	QTY: 1 x 45mg	Refills: 1
☐≤ 100 kg Maintenance Dose: 45 mg SQ every 12 Weeks ☐Other_____	QTY: 1 x 45mg	Refills:
☐> 100 kg Starter Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 Weeks of initial dose (week 4)	QTY: 1 x 90mg	Refills: 1
☐> 100 kg Maintenance Dose: 90 mg SQ every 12 Weeks ☐Other_____	QTY: 1 x 90mg	Refills:

☐**Taltz® Autoinjector 80 mg/mL** ☐**Taltz® Prefilled Syringe 80 mg/mL** **Pens will be dispensed if no preference is indicated*

☐Starter Dose for Plaque Psoriasis: 160 mg (two 80 mg inj.) at Week 0, then 80 mg at Week 2,4,6,8,10,12	QTY: 8	Refills: 0
☐Maintenance Dose for Plaque Psoriasis: 80 mg every 4 weeks	QTY: 1	Refills:
☐Starting Dose for Psoriatic Arthritis: 160 mg (two 80 mg inj.) at Week 0	QTY: 2	Refills: 0
☐Maintenance Dose for Psoriatic Arthritis: 80 mg every 4 Weeks	QTY: 1	Refills:
☐Other_____	QTY:	Refills:

☐**Tremfya® pen autoinjector 100 mg/mL** ☐**Tremfya® prefilled syringe 100 mg/mL** **Pen will be dispensed if no preference is indicated*

☐Starter Dose: 100 mg SQ at Week 0, 4, and every 8 Weeks thereafter	QTY: 1	Refills: 0
☐Maintenance Dose: 100 mg SQ every 8 Weeks (starting at week 4)	QTY: 1	Refills:

☐**Xeljanz® 5mg tablet** ☐**Xeljanz 10mg tablet** ☐**Xeljanz 11mg ER tablet**

☐5mg tablet po twice daily	QTY: 1 month	Refills:
☐10mg tablet po twice daily	QTY: 1 month	Refills:
☐11mg tablet po once daily	QTY: 1 month	Refills:

☐**Xolair® 150 mg PFS** ☐ **Xolair® 150 mg vial**

☐150mg ☐300mg SQ every 4 Weeks — QTY: 28 day supply — Refills:

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

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ev: 7.25.22