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.

Hu-Z 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).

Humira® ☐CF Pen 40 mg/0.4 mL NDC: 0074-0554-02 ☐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: _____
☐Maintenance Dose for Hidradenitis Suppurativa: 40 mg SQ Day 29 and every week thereafter	QTY: 1 month	Refills: _____
☐Other	QTY: _____	Refills: _____

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

☐ 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: ____
☐ 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: ____

Yusimry® ☐ 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: ____

Yuflyma® ☐ 40mg/0.4ml pen OR ☐ 40mg/0.4ml syringe OR ☐ 40mg/0.4ml syringe with safety guard

☐ 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 supply	QTY: 2 pens/syringes	Refills: 0
☐ Maintenance dose for Psoriasis: 40mg SQ every week (starting on day 8)	QTY: 4 pens/syringes	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.