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.

S-Z 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).

Medication / Dose	QTY	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	1 box (2 PFS)	0
☐Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks. (starting at week 2)	1 box (2 PFS)	____
Simponi® ☐ Aria 50 mg/4 mL Patient weight (kg): ____________ — ☐**Enroll in SimponiOne® Program**		
☐Starter Dose: 2 mg/kg IV at weeks 0 and 4	1 month	0
☐Maintenance Dose: 2 mg/kg IV every 8 weeks	QS for 8 weeks	____
Simponi® ☐SmartJect 50 mg/0.5 mL ☐Prefilled Syringe 50 mg/0.5 mL *Pens will be dispensed if no preference is indicated		
☐ 50 mg SQ every month	1 month	____
☐ Other: ____________________	____	____
Skyrizi® ☐Pen autoinjector 150mg/mL ☐Prefilled syringe 150mg/ml *Pens will be dispensed if no preference is indicated		
☐ Starter dose: 150 mg SQ at Week 0 and 4	1	0
☐ Maintenance Dose: 150 mg SQ every 12 Weeks	1	____
Sotyku® ☐6mg po once daily	____	____
Stelara® ☐Prefilled Syringe ☐Vial ☐MD's Office Infusion ☐Home Infusion Supplies Required *Prefilled syringe will be dispensed if preference is not indicated — ☐Enroll in Janssen CarePath Program		
☐≤ 100 kg Starter Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 Weeks of initial dose (week 4)	1 x 45mg	1
☐≤ 100 kg Maintenance Dose: 45 mg SQ every 12 Weeks ☐Other____________	1 x 45mg	____
☐> 100 kg Starter Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 Weeks of initial dose (week 4)	1 x 90mg	1
☐> 100 kg Maintenance Dose: 90 mg SQ every 12 Weeks ☐Other____________	1 x 90mg	____
Taltz® ☐Autoinjector 80 mg/mL ☐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	8	0
☐Maintenance Dose for Plaque Psoriasis: 80 mg every 4 weeks	1	____
☐Starting Dose for Psoriatic Arthritis: 160 mg (two 80 mg inj.) at Week 0	2	0
☐Maintenance Dose for Psoriatic Arthritis: 80 mg every 4 Weeks	1	____
☐Other____________________	____	____
Tremfya® ☐Pen autoinjector 100 mg/mL ☐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	1	0
☐Maintenance Dose: 100 mg SQ every 8 Weeks (starting at week 4)	1	____
Xeljanz® ☐5mg tablet ☐10mg tablet ☐11mg ER tablet		
☐1 tablet po twice daily	1 month	____
Xolair® ☐Prefilled Syringe 150 mg ☐ Vial 150 mg		
☐150mg SQ every 4 weeks ☐300mg SQ every 4 weeks	28 day supply	____

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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