

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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:		Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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: <input type="checkbox"/> L28.1 Prurigo nodularis <input type="checkbox"/> L40.0 Psoriasis <input type="checkbox"/> L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis <input type="checkbox"/> L40.59 <input type="checkbox"/> L50.1 Chronic Idiopathic Urticaria <input type="checkbox"/> L73.2 Hidradenitis Suppurativa <input type="checkbox"/> Other: _____					
<ul style="list-style-type: none"> ▪ Location: <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Face <input type="checkbox"/> Scalp <input type="checkbox"/> Groin <input type="checkbox"/> Nails <input type="checkbox"/> Others: _____ ▪ Severity: <input type="checkbox"/> Mild (up to 3% BSA) <input type="checkbox"/> Moderate (3-10% BSA) <input type="checkbox"/> Severe (<i>greater than 10% BSA</i>), BSA _____ % 					
If treated previously for this condition, please indicate which drugs have been tried and failed: _____ Date range of previous therapy: _____					
<ul style="list-style-type: none"> ▪ Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type/ medication(s): _____ ▪ Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes, how long should patient wait before starting the new medication? _____ ▪ Has patient received a PPD (tuberculosis) Skin Test? <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.					
PRESCRIPTION INFORMATION					
<input type="checkbox"/> 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® <input type="checkbox"/> CF Pen 40 mg/0.4 mL NDC: 0074-0554-02 <input type="checkbox"/> CF 40 mg/0.4 mL Syringe NDC: 0074-0243-02 <small>*Pen will be dispensed if no preference indicated</small>					
<input type="checkbox"/> Maintenance Dose for Psoriasis: 40 mg SQ once every other week		QTY: <u>1 month</u>	Refills: _____		
<input type="checkbox"/> Maintenance Dose for Hidradenitis Suppurativa: 40 mg SQ Day 29 and every week thereafter		QTY: <u>1 month</u>	Refills: _____		
<input type="checkbox"/> Other		QTY: _____	Refills: _____		
Hyrimoz® <input type="checkbox"/> 40mg/0.8ml pen OR <input type="checkbox"/> 40mg/0.8ml syringe					
<input type="checkbox"/> Starter dose for Psoriasis: 80mg SQ as single dose, 7 day supply		QTY: 2 pens/syringes	Refills: <u>0</u>		
<input type="checkbox"/> Maintenance dose for Psoriasis: 40mg SQ every other week (starting on day 8)		QTY: 2 pens/syringes	Refills: _____		
<input type="checkbox"/> 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: <u>0</u>		
<input type="checkbox"/> Maintenance dose for Hidradenitis Suppurativa: 40mg SQ every week (starting on day 29 from beginning of starter dose)		QTY: 4 pens/syringes	Refills: _____		
Yusimry® <input type="checkbox"/> 40mg/0.8ml syringe					
<input type="checkbox"/> 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: <u>0</u>		
<input type="checkbox"/> Maintenance dose for Hidradenitis Suppurativa: 40mg SQ every week (starting on day 29 from beginning of starter dose)		QTY: 4 syringes	Refills: _____		
<input type="checkbox"/> Starter dose for Psoriasis: 80mg SQ as single dose, 7 day supply		QTY: 2 syringes	Refills: <u>0</u>		
<input type="checkbox"/> Maintenance dose for Psoriasis: 40mg SQ every week (starting on day 8)		QTY: 4 syringes	Refills: _____		
Yuflyma® <input type="checkbox"/> 40mg/0.4ml pen OR <input type="checkbox"/> 40mg/0.4ml syringe OR <input type="checkbox"/> 40mg/0.4ml syringe with safety guard					
<input type="checkbox"/> 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: <u>0</u>		
<input type="checkbox"/> Maintenance dose for Hidradenitis Suppurativa: 40mg SQ every week (starting on day 29 from beginning of starter dose)		QTY: 4 pens/syringes	Refills: _____		
<input type="checkbox"/> Starter dose for Psoriasis: 80mg SQ as single dose, 7 day supply		QTY: 2 pens/syringes	Refills: <u>0</u>		
<input type="checkbox"/> 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 referring pharmacy to forward this prescription to another pharmacy, if needed.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document.