

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: <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"/> 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"/> L73.2 Hidradenitis Suppurativa <input type="checkbox"/> Other: _____ 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 (greater than 10% BSA), BSA _____ % <input type="checkbox"/> L50.1 Chronic Idiopathic Urticaria If treated previously for this condition, please indicate which drugs have been tried and failed: _____ Date range of previous therapy: _____ <input type="checkbox"/> Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type/ medication(s): _____ <input type="checkbox"/> 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? _____ <input type="checkbox"/> 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).				
<input type="checkbox"/> Cibinqo 50mg tablet <input type="checkbox"/> Cibinqo 100mg tablet <input type="checkbox"/> Cibinqo 200mg tablet <input type="checkbox"/> 1 tablet po once daily <input type="checkbox"/> Other _____ QTY: <u>1 month</u> Refills: _____				
<input type="checkbox"/> Cosentyx™ 150 mg/mL Sensoready® Pen <input type="checkbox"/> Cosentyx™ Prefilled Syringe 150 mg/mL <input type="checkbox"/> Cosentyx™ 150 mg Vial of Lyophilized powder <small>*Sensoready® pen will be dispensed if no preference indicated</small> <input type="checkbox"/> Starter Dose: 300 mg SQ initially (Weeks 0, 1, 2, 3 and 4) then 300 mg SQ every 4 Weeks thereafter (Week 4) QTY: <u>5 weeks</u> Refills: <u>0</u> <input type="checkbox"/> Starter Dose not needed <input type="checkbox"/> Maintenance Dose: 300 mg SQ every 4 Weeks QTY: <u>1 month</u> Refills: _____ <input type="checkbox"/> Other _____				
<input type="checkbox"/> Dupixent® (Dupilumab) 300 mg pen autoinjector <input type="checkbox"/> Dupixent® (Dupilumab) 300 mg prefilled syringe <small>*pen will be dispensed if no preference indicated</small> <input type="checkbox"/> Starter Dose: Inj. 600 mg SQ on Day 1, then 300 mg SQ every 2 Weeks starting on Day 15 QTY: <u>QS for starter</u> Refills: <u>0</u> <input type="checkbox"/> Starter Dose not needed <input type="checkbox"/> Maintenance Dose: Inj. 300 mg (1 syringe) SQ every 2 Weeks QTY: <u>1 month</u> Refills: _____				
<input type="checkbox"/> Enbrel® 50 mg/ml SureClick (autoinjector) <input type="checkbox"/> Enbrel® 50 mg Prefilled Syringe <input type="checkbox"/> Enbrel® Mini 50 mg Cartridge <input type="checkbox"/> Enroll in Enliven® Program <small>*SureClick will be dispensed if no preference indicated</small> <input type="checkbox"/> Starter Dose: 50 mg SQ twice weekly (72-96 hours apart) for 3 months QTY: <u>1 month</u> Refills: <u>2</u> <input type="checkbox"/> Starter Dose not needed <input type="checkbox"/> Maintenance Dose: 50 mg SQ weekly <input type="checkbox"/> Other _____ QTY: <u>1 month</u> Refills: _____				
<input type="checkbox"/> Enbrel® 25 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> Enbrel® 25 mg Single-Use Vial <small>*Prefilled Syringe will be dispensed if no preference indicated</small> <input type="checkbox"/> 25 mg SQ twice weekly (72-96 hours apart) <input type="checkbox"/> Other _____ QTY: <u>1 month</u> Refills: _____				
<input type="checkbox"/> Erivedge® 150 mg Capsules Take 1 Capsule Orally Once Daily QTY: <u>28 capsules</u> Refills: _____				
<input type="checkbox"/> Humira® CF Pen Psoriasis Starter Kit NDC: 0074-1539-03 <input type="checkbox"/> Humira® Prefilled Syringe CF 40 mg/ 0.4 mL NDC: 0074-0243-02 <input type="checkbox"/> Enroll in Humira Complete Program <small>*Pen Starter Kit will be dispensed if not checked</small> <input type="checkbox"/> Starter Dose for Psoriasis: <input type="checkbox"/> One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 (OR) QTY: <u>3 pens</u> Refills: <u>0</u> <input type="checkbox"/> Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 QTY: <u>4 syringes</u> Refills: <u>0</u> <input type="checkbox"/> Starter Dose not needed.				
<input type="checkbox"/> Humira® CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 <input type="checkbox"/> Humira® 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: _____				

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.

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DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION			
Patient Name:		DOB:	
Address:	City:	State:	Zip:
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID:	
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).			
<input type="checkbox"/> Humira® Starter Pkg CF 80 mg/0.8 mL Pen NDC: 0074-0124-03 <input type="checkbox"/> Humira® CF Prefilled Syringe 40 mg/0.4 mL NDC: 0074-0243-02 <i>*Pen will be dispensed if no preference is indicated</i>			
<input type="checkbox"/> Starter Dose for Hidradenitis Suppurativa: <input type="checkbox"/> Inj 160 mg SQ day 1, then 80 mg SQ day 15 (OR)		QTY: <u>1 month</u>	Refills: <u>0</u>
<input type="checkbox"/> Inj 80 mg SQ day 1, and 80 mg SQ day 2, then 80 mg SQ day 15		QTY: <u>1 month</u>	Refills: <u>0</u>
<input type="checkbox"/> Starter Dose not needed.			
<input type="checkbox"/> Humira® CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 <input type="checkbox"/> Humira® CF 40 mg/0.4 mL Syringe NDC: 0074-0243-02			
<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: _____
<input type="checkbox"/> Ilumya™ 100 mg/mL Prefilled Syringes			
<input type="checkbox"/> Starter Dose: 100 mg SQ on Week 0 and Week 4		QTY: <u>1 month (1 PFS)</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: 100 mg SQ every 12 weeks (starting at week 4)		QTY: <u>1 syringe</u>	Refills: _____
<input type="checkbox"/> Kevzara® (Sarilumab) pen autoinjector 200 mg/1.14 mL <input type="checkbox"/> Kevzara® (Sarilumab) prefilled syringe 200 mg/1.14 mL <i>Pens will be dispensed if no preference is indicated</i>			
<input type="checkbox"/> 200 mg subcutaneously every 2 Weeks		QTY: <u>1 box (2)</u>	Refills: _____
Odomzo® 200 mg Capsule PO Once Daily		QTY: <u>30 caps</u>	Refills: _____
Otezla® Tablets			
<input type="checkbox"/> 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: 20 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: <u>1 month</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: 30 mg twice daily		QTY: <u>60 tabs (30mg)</u>	Refills: _____
<input type="checkbox"/> Other _____		QTY: _____	Refills: _____
<input type="checkbox"/> Remicade® 100 mg Vial <input type="checkbox"/> Inflectra® 100 mg Powder Vial <input type="checkbox"/> Renflexis® 100 mg Powder Vial <input type="checkbox"/> Avsola® 100 mg Powder Vial			
<input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required		<input type="checkbox"/> Enroll in AccessOneSM Program	
<input type="checkbox"/> Starter Dose: _____ mg IV on Week 0, Week 2, Week 6, then _____		QTY: <u>QS 3 infusions</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: _____ mg IV every _____ Weeks		QTY: <u>QS 1 infusions</u>	Refills: _____
<input type="checkbox"/> Rinvoq 15mg tablet <input type="checkbox"/> Rinvoq 30mg tablet			
<input type="checkbox"/> 1 tablet po once daily		QTY: <u>1 month</u>	Refills: _____
<input type="checkbox"/> Siliq® 210 mg/1.5 mL Prefilled Syringe (2 pack)			
<input type="checkbox"/> Starter Dose for Plaque Psoriasis: 210 mg SQ at weeks 0, 1 and 2, followed by maintenance dose.		<input type="checkbox"/> Enroll in REMS Program	
<input type="checkbox"/> Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks. (starting at week 2)		QTY: <u>1 box (2 PFS)</u>	Refills: <u>0</u>
		QTY: <u>1 box (2 PFS)</u>	Refills: _____
<input type="checkbox"/> Simponi® Aria 50 mg/4 mL Patient weight (kg): _____			
<input type="checkbox"/> Starter Dose: 2 mg/kg IV at weeks 0 and 4		<input type="checkbox"/> Enroll in SimponiOne® Program	
<input type="checkbox"/> Maintenance Dose: 2 mg/kg IV every 8 weeks		QTY: <u>1 month</u>	Refills: <u>0</u>
		QTY: <u>QS for 8 weeks</u>	Refills: _____
<input type="checkbox"/> Simponi® SmartJect 50 mg/0.5 mL <input type="checkbox"/> Simponi® Prefilled Syringe 50 mg/0.5 mL <i>*Pens will be dispensed if no preference is indicated</i>			
<input type="checkbox"/> 50 mg SQ every month		QTY: <u>1 month</u>	Refills: _____
<input type="checkbox"/> Other: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Skyriz® Pen autoinjector 150mg/mL <input type="checkbox"/> Skyriz® prefilled syringe 150mg/ml <i>*Pens will be dispensed if no preference is indicated</i>			
<input type="checkbox"/> Starter dose: 150 mg SQ at Week 0 and 4		QTY: <u>1</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: 150 mg SQ every 12 Weeks		QTY: <u>1</u>	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.

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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:	
Address:	City:	State:	Zip:
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID:	
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).			
<input type="checkbox"/> Stelara® Prefilled Syringe <input type="checkbox"/> Stelara® Vial <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required		<input type="checkbox"/> Enroll in Janssen CarePath Program	
<small>*Pre-filled syringe will be dispensed if preference is not indicated</small>			
<input type="checkbox"/> ≤ 100 kg Starter Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 Weeks of initial dose (week 4)		QTY: <u>1 x 45mg</u>	Refills: <u>1</u>
<input type="checkbox"/> ≤ 100 kg Maintenance Dose: 45 mg SQ every 12 Weeks <input type="checkbox"/> Other _____		QTY: <u>1 x 45mg</u>	Refills: _____
<input type="checkbox"/> > 100 kg Starter Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 Weeks of initial dose (week 4)		QTY: <u>1 x 90mg</u>	Refills: <u>1</u>
<input type="checkbox"/> > 100 kg Maintenance Dose: 90 mg SQ every 12 Weeks <input type="checkbox"/> Other _____		QTY: <u>1 x 90mg</u>	Refills: _____
<input type="checkbox"/> Taltz® Autoinjector 80 mg/mL <input type="checkbox"/> Taltz® Prefilled Syringe 80 mg/mL <small>*Pens will be dispensed if no preference is indicated</small>			
<input type="checkbox"/> 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: <u>8</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose for Plaque Psoriasis: 80 mg every 4 weeks		QTY: <u>1</u>	Refills: _____
<input type="checkbox"/> Starting Dose for Psoriatic Arthritis: 160 mg (two 80 mg inj.) at Week 0		QTY: <u>2</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose for Psoriatic Arthritis: 80 mg every 4 Weeks		QTY: <u>1</u>	Refills: _____
<input type="checkbox"/> Other _____		QTY: _____	Refills: _____
<input type="checkbox"/> Tremfya® pen autoinjector 100 mg/mL <input type="checkbox"/> Tremfya® prefilled syringe 100 mg/mL <small>*Pen will be dispensed if no preference is indicated</small>			
<input type="checkbox"/> Starter Dose: 100 mg SQ at Week 0, 4, and every 8 Weeks thereafter		QTY: <u>1</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: 100 mg SQ every 8 Weeks (starting at week 4)		QTY: <u>1</u>	Refills: _____
<input type="checkbox"/> Xeljanz® 5mg tablet <input type="checkbox"/> Xeljanz 10mg tablet <input type="checkbox"/> Xeljanz 11mg ER tablet			
<input type="checkbox"/> 5mg tablet po twice daily		QTY: <u>1 month</u>	Refills: _____
<input type="checkbox"/> 10mg tablet po twice daily		QTY: <u>1 month</u>	Refills: _____
<input type="checkbox"/> 11mg tablet po once daily		QTY: <u>1 month</u>	Refills: _____
<input type="checkbox"/> Xolair® 150 mg PFS <input type="checkbox"/> Xolair® 150 mg vial			
<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg SQ every 4 Weeks		QTY: <u>28 day supply</u>	Refills: _____

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

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