

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: _____ 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).					
<input type="checkbox"/> Cosentyx™ 150 mg/mL Prefilled Syringe (OR) <input type="checkbox"/> Cosentyx™ 150 mg/mL Sensoready® Pen (OR) <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 </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 </u>	Refills: <u> </u>	
<input type="checkbox"/> Other _____					
<input type="checkbox"/> Dupilent® (Dupilumab) 300 mg Prefilled Syringe					
<input type="checkbox"/> Starter Dose: Inj. 600 mg (2 syringes) SQ on Day 1, then 300 mg (1 syringe) SQ every 2 Weeks starting on Day 15			QTY: <u> 2 </u> cartons (4 syringes)	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 </u> cartons (2 syringes)	Refills: <u> </u>	
<input type="checkbox"/> Enbrel® 50 mg/ml SureClick (autoinjector) (OR) <input type="checkbox"/> Enbrel® 50 mg Prefilled Syringe (OR) <input type="checkbox"/> Enbrel® Mini 50 mg Cartridge					
<small>*SureClick will be dispensed if no preference indicated</small>					
<input type="checkbox"/> Starter Dose: 50 mg SQ twice weekly (72-96 hours apart)			QTY: <u> 8 </u>	Refills: <u> 0 </u>	
<input type="checkbox"/> Starter Dose not needed					
<input type="checkbox"/> Maintenance Dose: 50 mg SQ weekly <input type="checkbox"/> Other _____			QTY: <u> 4 </u>	Refills: <u> </u>	
<input type="checkbox"/> Enbrel® 25 mg/0.5 mL Prefilled Syringe (OR) <input type="checkbox"/> Enbrel® 25 mg Multiple-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> 8 </u>	Refills: <u> </u>	
<input type="checkbox"/> Erivedge® 150 mg Capsules Take 1 Capsule Orally Once Daily					
			QTY: <u> 28 </u>	Refills: <u> </u>	
<input type="checkbox"/> Humira® Pen Psoriasis Starter Kit CF 80 mg/ 0.8 mL NDC: 0074-1539-03 (OR) <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 </u> pens	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 </u> syringes	Refills: <u> 0 </u>	
<input type="checkbox"/> Starter Dose not needed.					
<input type="checkbox"/> Maintenance Dose: 40 mg SQ once every other week			QTY: <u> 2 </u>	Refills: <u> </u>	
<input type="checkbox"/> Other _____			QTY: <u> </u>	Refills: <u> </u>	
<input type="checkbox"/> Humira® Starter Pkg CF 80 mg/0.8 mL Pen NDC: 0074-0124-03 (OR) <input type="checkbox"/> Humira® CF Prefilled Syringe 40 mg/0.4 mL NDC: 0074-0243-02					
<small>*Pen will be dispensed if not checked</small>					
<input type="checkbox"/> Starter Dose for Hidradenitis Suppurativa: <input type="checkbox"/> Two 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 15 (OR)			QTY: <u> 6 </u>	Refills: <u> </u>	
<input type="checkbox"/> One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15			QTY: <u> </u>	Refills: <u> </u>	
<input type="checkbox"/> Humira® CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 (OR) <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> 4 </u>	Refills: <u> </u>	
<input type="checkbox"/> Other _____			QTY: <u> </u>	Refills: <u> </u>	

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.

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. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

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"/> Ilumya™ 100 mg/mL Prefilled Syringes			
<input type="checkbox"/> Starter Dose: 100 mg SQ on Week 0 and Week 4		QTY: <u>1 month (2 PFS)</u>	Refills: <u>0</u>
<input type="checkbox"/> Maintenance Dose: 100 mg SQ every 12 weeks		QTY: _____	Refills: _____
<input type="checkbox"/> Kezvara® (Sarilumab) Prefilled Syringes 200 mg/1.14 mL 200 mg subcutaneously every 2 Weeks			
		QTY: <u>1 box (2 syringes)</u>	Refills: _____
<input type="checkbox"/> Odomzo® 200 mg Capsule <input type="checkbox"/> 200 mg PO Once Daily			
		QTY: <u>4</u>	Refills: _____
<input type="checkbox"/> 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: 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: <u>1 month</u>	Refills: _____
<input type="checkbox"/> Maintenance Dose: 30 mg twice daily		QTY: <u>1 month</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"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required			
<input type="checkbox"/> Starter Dose: _____ mg IV on Week 0, Week 2, Week 6, then _____		<input type="checkbox"/> Enroll in AccessOneSM Program	
<input type="checkbox"/> Maintenance Dose: _____ mg IV every _____ Weeks		QTY: <u>QS 3 infusions</u>	Refills: <u>0</u>
		QTY: <u>QS 1 infusions</u>	Refills: <u>0</u>
<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.		QTY: <u>2 packs (4 PFS)</u>	Refills: <u>0</u>
		QTY: <u>1 packs (2 PFS)</u>	Refills: _____
<input type="checkbox"/> Simponi® Aria 50 mg/4 mL			
<input type="checkbox"/> Starter Dose: 2 mg IV at weeks 0 and 4		<input type="checkbox"/> Enroll in SimponiOne® Program	
<input type="checkbox"/> Maintenance Dose: 2 mg IV every 8 weeks		QTY: _____	Refills: <u>0</u>
		QTY: _____	Refills: _____
<input type="checkbox"/> Simponi® SmartJect 50 mg/0.5 mL (OR) <input type="checkbox"/> Simponi® Prefilled Syringe 50 mg/0.5 mL *Pen will be dispensed in preference is not indicated			
<input type="checkbox"/> 50 mg SQ every month		QTY: <u>1</u>	Refills: _____
<input type="checkbox"/> Other: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Skyrizi® Prefilled Syringe 75 mg/0.83 mL (2 pack)			
<input type="checkbox"/> Starter dose: 150 mg SQ (two 75 mg injections) at Week 0 and 4		QTY: <u>1</u>	Refills: _____
<input type="checkbox"/> Maintenance Dose: 150 mg (two 75 mg injections) SQ every 12 Weeks		QTY: _____	Refills: _____
<input type="checkbox"/> Stelara® Prefilled Syringe (OR) <input type="checkbox"/> Stelara® Vial <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required			
<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</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</u>	Refills: <u>1</u>
<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</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</u>	Refills: <u>1</u>
<input type="checkbox"/> Taltz® Autoinjector 80 mg/mL (OR) <input type="checkbox"/> Taltz® Prefilled Syringe 80 mg/mL			
<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>4</u>	Refills: <u>1</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® Prefilled Syringe 100 mg/mL			
<input type="checkbox"/> Starter Dose: 100 mg SQ at Week 0, 4, and every 8 Weeks thereafter		QTY: _____	Refills: _____
<input type="checkbox"/> Maintenance Dose: 100 mg SQ every 8 Weeks		QTY: _____	Refills: _____
<input type="checkbox"/> Xolair® 150 mg <input type="checkbox"/> Vial (OR) <input type="checkbox"/> Pre-filled Syringe			
<input type="checkbox"/> 150mg (OR) <input type="checkbox"/> 300mg SQ every 4 Weeks		QTY: <u>28 day supply</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. Prescriber authorizes AcariaHealth 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. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.