## **DERMATOLOGY REFERRAL FORM (A-C)**

**PHONE** 888.370.1724 | **FAX** 877.645.7514



PATIENT INFORM	IATION															
Last Name		First Name	DO	В		Gender □ M □	∃F	Last 4 SSN		F	rimary La	nguage				
Address					City				State			ZIP				
Email		Home	e Phone		•	Work Phon	ie				Cell Pho	one				
Primary Contact Metho	od (check one)	☐ Cell Phone	☐ Home Phone	☐ Work Phone	□ Tex	kt 🗆 Email 🛭	□ Prin	nary Caregiver	□ DO	NOT C	ONTACT					
Primary Caregiver/Alt	Contact Name (If	f applicable)		Alt Conta	ct Email					A	Alt Contact	t Phone				
PRESCRIBER INF	ORMATION															
Name of Contact Send	ling Referral			Title			Prefer	red Contact Met	hod (cl	neck on	e) 🗆 Em	nail 🗆 Pho	ne [	□ Fax		
Referral Contact Email	l					Office Phone				Office	Fax					
Practice / Facility Nam	пе					Prescriber Nam	ne / Sp	ecialty								
Address						ty					State					
Prescriber State Licens	se #	DEA#			NF	PI #				Medica	id UPIN #					
		* Pleas	e include a (	copy of the	e fron	t and back	of in	nsurance ca	rd *							
CLINICAL INFORI	MATION - Ple	ease include a	applicable cli	nical chart n	otes											
Prescription Type	Naïve/New Start	☐ Therapy Resta	art 🗆 Existing T	reatment			TI	nerapy Start Date	e							
Sample/Starter Produc	ct Provided? 🗆 Ye	es □ No If yes, P	Provide Qty:	Date	e Sample	e Provided										
If Self-injectable drug,	is injection traini	ing coordination r	equired by our ph	harmacy? 🗆 Ye	s 🗆 No	1	Т	3 Test Results			Test D	ate				
Other/Concomitant Me	edications (please	e list)														
Allergies □ NKDA	□ Latex □ Dru	g Allergies (pleas	e list)			□ Ot	ther (p	lease list)								
Ship to Address ☐ Ho	ome 🗆 Prescrib	ber's Office 🗆 C	Other (please list)													
Patient Height (cm/in)	P	Patient Weight (kg	ı/lbs)	Date Obtaine	ed		% BS	A impacted			BSA Are	eas impacted				
	.9 Atopic dermat .1 Prurigo nodulai		☐ L40.0 Psorias	sis vulgaris 🗆	L40.50 A	Arthropathic pso		unspecified  of Diagnosis _		lidrade	nitis, supp	urativa				
PRESCRIPTION IN	VEORMATION	V - Please Esc	ribe if requir	ed by state	law											
In order for a brand	name product	to be dispensed	d, the prescribe	er must handw	rite "Br											
or your state-specific		guage to pronib.			not a va	alia prescriptioi	n forr	n for writing c	ontroll	ea me	aications					
MEDICATION	DOSE		DIRECTION	IS								QTY		REFILLS		
☐ Bimzelx																
	☐ 160mg/ml Aut		Initial Dose: ☐ 320mg (2		ice every	/ 4 weeks for 16 v	weeks									
				2x160mg) SC on	ice every	/ 4 weeks for 16 v	weeks						2			
			☐ 320mg (2 Maintenanc	2x160mg) SC on	-		weeks					:	2			
□ Cibingo	□ 160mg/ml Syr	ringe	☐ 320mg (2 Maintenanc ☐ 320mg (2	2x160mg) SC on e Dose: 2x160mg) SC on	ice every	/ 8 weeks			time ea	ch day		:	2			
□ Cibingo	☐ 160mg/ml Syr	ringe t	☐ 320mg (2 Maintenanc ☐ 320mg (2	2x160mg) SC on e Dose: 2x160mg) SC on	ice every				time ea	ch day.		:				
	☐ 160mg/ml Syr☐ 50 mg Tablet☐ 100 mg Tablet☐ 200 mg Tablet☐ 200 mg Table	ringe t t	☐ 320mg (2  Maintenanc ☐ 320mg (2	e Dose: 2x160mg) SC or 2x160mg) SC or tablet by moutl	nce every	/ 8 weeks aily, with or with	out fo	od, at the same								
□ Cibinqo	☐ 160mg/ml Syr	t tst S	☐ 320mg (2  Maintenanc ☐ 320mg (2  ☐ Take one  ☐ (PsO) Inja ☐ (PsO) Alt	ect 400mg (as ternate load (pt	n once day	/ 8 weeks aily, with or with mg injections) su Inject 400mg (a	nout fo	od, at the same ineously every o 200mg injection	ther we	ek reeks 0,	, 2, and 4					
	☐ 160mg/ml Syn	t tst S	☐ 320mg (2  Maintenanc ☐ 320mg (2  ☐ Take one  ☐ (PsO) Inja ☐ (PsO) Alt ☐ (PsO) Alt	e Dose: 2x160mg) SC or tablet by mouth ect 400mg (as t ernate load (pt ernate mainten	n once do	, 8 weeks aily, with or with mg injections) su	ubcutas two-	od, at the same neously every o 200mg injection subcutaneously	ther we	eek reeks 0,	, 2, and 4 eek	3				
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Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

## **DERMATOLOGY** REFERRAL FORM (D-I)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

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PATIENT INFORM	IATION															
Last Name	First Name			DOB			Gender □ M	□F	Last 4 SSN			rimary L				
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Primary Contact Metho	od (check one)	☐ Cell Phone	☐ Home Phone	□Work	Phone $\square$	Text	t 🗆 Email	□ Pri	imary Caregiver	□ DO	NOT C	ONTACT	-			
Primary Caregiver/Alt	Contact Name (I	applicable)		Alt (	Contact Em	nail					А	It Conta	ct Phone			
PRESCRIBER INF	ORMATION															
Name of Contact Sending Referral Title Preferred Co									erred Contact Met	hod (cl	neck one	e) 🗆 E	mail 🗆 I	hone	□ Fax	
Referral Contact Email							Office Phone				Office	Fax				
Practice / Facility Name Prescriber Name / Specialty																
Address						Cit	У					State		ZIP		
Prescriber State Licens	se #	DEA#				NP	1#				Medicai	id UPIN #	#			
		* Pleas	e include a	сору о	f the fro	ont	t and back	cof	insurance ca	ard *						
CLINICAL INFOR	MATION - Ple	ease include	applicable cli	nical ch	art note	S										
Prescription Type 🗆 N	laïve/New Start	☐ Therapy Rest	art 🗆 Existing T	reatment					Therapy Start Date	е						
Sample/Starter Produc	ct Provided? 🗆 Y	es 🗆 No If yes, I	Provide Qty:		Date San	nple	Provided									
If Self-injectable drug,	is injection train	ng coordination	required by our pl	harmacy?	☐ Yes ☐	No			TB Test Results			Test	Date			
Other/Concomitant Me	edications (pleas	e list)						·								
Allergies □ NKDA	□ Latex □ Dru	g Allergies (plea	se list)					Other	(please list)							
Ship to Address ☐ Ho	ome 🗆 Prescri	ber's Office 🗆 🤇	Other (please list)													
Patient Height (cm/in) Patient Weight (kg/lbs) Date Obtained % BSA impacted BSA Areas								reas impa	s impacted							
ICD-10 Codes																
PRESCRIPTION II	NFORMATIO	N - Please Es	cribe if requir	ed by s	tate law											
In order for a brand or your state-specifi													nc			
MEDICATION	DOSE	luage to promit	DIRECTION		III IS TIOL B		ia prescriptio	<i>311 10.</i>	ini ioi wiiting c	Oriti Oli	eu mei	arcation		TY	REFILLS	
□ Dupixent*	300mg ☐ Pen ☐	DES w/Shield			a (as two-3	(OOm	na injections ir	diffo	rent sites) on day	1 then	inject 3	00ma		'''	REFILES	
□ Dupixent	300mg - Fem	PP3 W/3IIIeIu	every oth	<ul> <li>□ Load: Inject 600mg (as two-300mg injections in different sites) on day 1, then inject 300mg every other week starting on day 15</li> <li>□ Maintenance: Inject 300mg subcutaneously every other week</li> </ul>												
	200mg □ Pen □	PFS w/Shield	every oth	☐ Load: Inject 400mg (as two-200mg injections in different sites) on day 1, then inject 200mg every other week starting on day 15 ☐ Maintenance: Inject 200mg subcutaneously every other week												
□ Enbrel*	☐ 50 mg PFS			□ Load: Inject 50mg subcutaneously twice a week, 72-96 hours apart x3 months □ Maintenance: Inject 50mg subcutaneously once a week												
	☐ 50 mg Mini C	PFS		Other:												
- Francisco	☐ 25 mg SDV 2% Ointment			Pediatric Weight: Date Taken:												
□ Eucrisa	☐ 60gm ☐ 100gm		□ Арріу а і	illil layer t	o arrected	area	a(s) twice daily	,								
☐ Humira CF (Plaque Psoriasis)	☐ Starter Pack ( 40 mg/0.4 mL	CF): 80 mg/0.8 r PENS		Initial Dose: ☐ Inject 80 mg SC on day 1, followed by 40 mg SC on Day 8 & Day 22								1	Starter Pack			
	□ 40 mg/0.4 m □ 40 mg/0.4 m		Maintenanc □ Inject 40 □ Other:		ery other v	week	ζ.									
☐ Humira CF (Hidradenitis Suppurativa)	☐ Starter Pack ( PENS	CF): 80 mg/0.8 r	☐ Inject 160	Initial Dose:  ☐ Inject 160mg (2 x 80 mg) SC on Day 1, then 80mg SC two weeks later (on Day 15).  ☐ Inject 80 mg SC on Day 1, 80 mg SC on Day 2, then 80 mg SC two weeks later (on Day 15).							1	Starter Pack				
	□ 40 mg/0.4 m □ 40 mg/0.4 m □ 80 mg/0.8 m	L (CF) PFS		mg SC on			very week there									
☐ Humira CF (Psoriatic Arthritis)	□ 40 mg/0.4 m □ 40 mg/0.4 m	L (CF) PEN	Maintenanc □ Inject 40 Other:	e Dose:												
□ Ilumya	□ 100mg/ml PF	S		Omg at We	eeks 0,4, ar	nd ev	very 12 weeks	therea	after							
Prescriber Signature			Date			Su	pervising Phys	sician	Signature (where	require	ed by sta	ate law)	 Date	!		

DAW (Dispense as Written) Date Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

Brand Necessary (must handwrite)

## **DERMATOLOGY** REFERRAL FORM (J-S)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

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PATIENT INFORM	MOITAN													
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Address					City				State	)	:	ZIP		
Email		Ho	me Phone			Work P	hone	hone Cell Phone						
Primary Contact Meth	od (check one)	☐ Cell Phone	☐ Home Phone	□ Work	Phone 🗆 1	ext 🗆 Email	□P	rimary Caregiver		о пот с	ONTACT			
Primary Caregiver/Alt	Contact Name (I	f applicable)		Alt	Contact Ema	nil				А	It Contact F	Phone		
PRESCRIBER INF	ORMATION													
Name of Contact Sen	ding Referral			Title			Pre	ferred Contact Me	thod (c	heck one	e) 🗆 Ema	il 🗆 Pho	ne [	∃Fax
Referral Contact Emai	il		1			Office Phor	ne			Office	Fax			
Practice / Facility Nar	ne					Prescriber	Name /	Specialty						
Address City										State		ZIP		
Prescriber State Licen	ise #	DEA #				NPI #				Medicai	d UPIN #			
		* Plea	se include a	сору о	f the fro	nt and ba	ck of	insurance c	ard *					
CLINICAL INFOR	MATION - PI	ease include	applicable cli	nical ch	art notes									
Prescription Type								Therapy Start Da	te					
Sample/Starter Produ						ole Provided		orapy otalic za						
If Self-injectable drug			-	narmacy?				TB Test Results			Test Da	te		
Other/Concomitant M											1.000.24			
	□ Latex □ Dru		ase list)			Г	□Other	(please list)						
Ship to Address ☐ H			Other (please list)					(1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.						
Patient Height (cm/in		Patient Weight (		Date O	btained		%1	BSA impacted			BSA Area	s impacte	d.	
ICD-10 Codes														
	3.1 Prurigo nodula		☐ Other					ate of Diagnosis			, ,			
PRESCRIPTION I														
In order for a brand or your state-specif														
MEDICATION	DOSE		DIRECTION									QTY		REFILLS
☐ Opzelura	☐ 1.5% Cream				ice daily to a	affected areas;	applica	ition area should n	ot exce	ed 20%	BSA. Do no			
			use more th	an 60 gra	ams (1 tube)	per week. Disc	continu	e when signs/sym	ptoms	resolve.				
☐ Orencia	☐ 250mg Vial ☐ 125mg PFS ☐ 125mg Clickjo	et Pen	Inject 125m	Inject 125mg Subcutaneously once weekly										
□ Otezla*	☐ Starter Pack ☐ 30mg Tablet				y 1 then twic outh twice d		cted							
□ Remicade	□ Vial (weight	based)				mg) IV at w mg) I								
Rinvoq	☐ 15 mg ER Tab	olet	☐ Take one	tablet by	mouth once	dailv						30		
	□ 30 mg ER Ta			☐ Take one tablet by mouth once daily										
			(For patient	ts 12-65 y	o with inade			ng QD & who are i	not taki	ng strong	g CYP3A4	30	)	
□ Siliq*	□ 210mg PFS			☐ Load: Inject 210mg subcutaneously on weeks 0, 1, and 2, then every 2 weeks thereafter ☐ Maintenance: Inject 210mg subcutaneously every 2 weeks										
☐ Simponi*	50mg 🗆 Smart.	Ject* □ PFS	Inject 50mg	g subcutai	neously once	e a month as di	irected							
□ Skyrizi™	150mg □ Pen □	PFS				eously on week cutaneously or		4, then every 12 w	eeks th	ereafter				
□ Stelara*	Stelara*													
Prescriber Signature			Date			Supervising P	hysiciar	n Signature (where	e requir	ed by sta	nte law)	Date		
DAW (Dispense as Written)			Date			Brand Necessa	Necessary (must handwrite)							

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## **DERMATOLOGY** REFERRAL FORM (T-Z)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Kernove	above portion be	Tore raxing. Frea	se complete the pres	scription ic	,,,,,	its entirety a	na rax with sect	ure cove	er sneet t	.o the mai	TIDEL ADOL	7e.	
PATIENT INFORM	1ATION												
Last Name	F	irst Name	DOB		Gen	der □M □F	Last 4 SSN		Prir	mary Langı	uage		
Address	1			City			,	State		z	ZIP.		
Email		Home P	hone			Work Phone				Cell Phone	9		
Primary Contact Meth	od (check one)	☐ Cell Phone ☐ F	Home Phone ☐ Work	Phone 🗆	Text	□ Email □ F	Primary Caregiver		NOT CO	NTACT			
Primary Caregiver/Alt	Contact Name (If a	pplicable)	Alt	Contact Em	ail				Alt	Contact Pl	hone		
PRESCRIBER INF	ORMATION												
Name of Contact Send			Title			Pre	eferred Contact M	ethod (c	heck one)	□ Email	□ Phone	e □ Fax	
Referral Contact Emai					Off	ice Phone		•	Office F				
Practice / Facility Nan					_	scriber Name	/ Specialty						
Address	···				City				S	State	7	ZIP	
Prescriber State Licen	se #	DEA#			NPI#				Medicaid				
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01 IN 11 IN 15 OF	MATION DI					IU Dack OI	ilisurance c	.aru					
CLINICAL INFOR	MATION - Plea	ise include api	plicable clinical ch	art notes	;		l						
Prescription Type 🗆 l	Naïve/New Start	☐ Therapy Restart	☐ Existing Treatment	1			Therapy Start Da	ate					
Sample/Starter Produ	ct Provided?   Yes	□ No If yes, Prov	vide Qty:	Date Sam	ple Pro	vided	1						
If Self-injectable drug,	, is injection training	g coordination req	uired by our pharmacy?	☐ Yes ☐ I	No		TB Test Results			Test Date	е		
Other/Concomitant M	edications (please	list)											
Allergies □ NKDA	☐ Latex ☐ Drug	Allergies (please li	st)			☐ Othe	r (please list)						
Ship to Address ☐ H	ome 🗆 Prescribe	er's Office 🗆 Oth	er (please list)										
Patient Height (cm/in)	) Pai	tient Weight (kg/lk	os) Date O	btained		%	BSA impacted			BSA Areas	s impacted		
	0.9 Atopic dermatit 3.1 Prurigo nodularis		L40.0 Psoriasis vulgari	is □ L40.50	0 Arthr		sis, unspecified [ Date of Diagnosis		- Hidradenit	is, suppura	ativa		
PRESCRIPTION II	NFORMATION	- Please Escri	be if required by s	tate law									
In order for a brand	name product to	be dispensed, t	the prescriber must h	andwrite '									
		age to pronibit s	substitutions. This for	m is not a	valid į	prescription t	orm for writing	control	iea meai	cations.			
MEDICATION	DOSE		DIRECTIONS								QTY	REFILLS	
□ Taltz*	80mg □ Autoinje □ PFS	ector	Load (Plaque psori then 80mg on wee Inject 80mg subcu Load (Psoriatic art	ek 2, then Inj Itaneously a hritis): Injec	ject 80 t week t 160m	mg subcutaned 12 g (as two-80m	ously every 2 week g injections) subc	ks (week	s 4-10), th	en			
☐ Tremfya*	100mg □ One-Pr □ PFS	ess Injector	☐ Starter: Inject 100n ☐ Maintenance: Inject				4, then every 8 w	eeks the	reafter				
□ Xeljanz	☐ 5mg Tablet ☐ 11mg XR Tablet		☐ Take one 5mg table☐ Take one 11mg table☐										
☐ Zoryve 0.3%	☐ 60 gm Tube		☐ Apply to affected a	area(s) once	daily								
Cream (3 mg roflumilast/gm)			□ Other:										
(=, =,				Involved area(s) of skin:									
☐ Other													
☐ Other													
☐ Other													
Prescriber Signature			Date		Super	vising Physicia	n Signature (wher	re require	ed by state	e law)	Date		
				Brand Necessary (must handwrite)									

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