ePrescribe to our pharmacy

Dermatology Referral Form

Prescriber's Name: ____________________

DEA #: ____________ NPI: ____________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________ Fax: ____________

Office Contact: ____________________

Date: ____________ Needs by Date: ____________

Language: ____________ ☐ Nursing Instruction Required

Ship to: ☐ Patient ☐ MD Office ☐ Other: ____________

PATIENT INFORMATION: Please complete the following or send patient demographic sheet.

Patient Name: ____________________ Date of Birth: ____________ Sex: ☐ M ☐ F

Address: ____________________ City, State, Zip: ____________________

Home Phone: ____________ Alternate: ____________ Email: ____________

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION: Please send recent clinical notes, current medications, labs, and tests to expedite the **Prior Authorization**.

Diagnosis: ____________ ICD-10: ____________ Height: ________ Weight: ________

Prior Failed Medications: ____________________ ☐ Treatment-naive

Duration and Reason for D/C: ____________________ Does the patient have a latex allergy? ☐ Yes ☐ No TB/PPD Test given? ☐ Yes ☐ No

Methotrexate contraindicated: ☐ Elderly or Disabled ☐ Pregnancy/Breastfeeding ☐ Social activities ☐ Patient is of child bearing age ☐ Chronic Liver Disease

Comments: ____________________

PRESCRIPTION INFORMATION

Medication	Strength	Directions/SIG	Quantity	Refill
☐ **Cosentyx**	☐ 150 mg/mL Sensoready Pen ☐ 150 mg/mL Prefilled Syringe	**Plaque Psoriasis/Arthritis Starter Dose:** ☐ Inject two 150 mg pens/syringes SC every week 0, 1, 2, 3, 4 (**NO REFILLS**)	5 Kits	X
		Plaque Psoriasis/Arthritis Maintenance Dose: ☐ Inject two 150 mg pens/syringes SC every 4 weeks		
☐ **Dupixent**	☐ 300 mg/2 mL Prefilled Syringe	**Starter Dose:** ☐ Inject two 300 mg/2ml syringes (**NO REFILLS**)		X
		Maintenance Dose: ☐ Inject one 300 mg/2ml syringe every other week		
☐ **Enbrel**	☐ 50 mg/mL Sureclick Autoinjector ☐ 50 mg/mL Prefilled Syringe	**Psoriasis Induction Dose:** ☐ Inject 50 mg SC 2x/week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
		Psoriasis Maintenance Dose: ☐ Inject 50 mg SC 1x/week		
☐ **Humira**	☐ Psoriasis/Uveitis Starter Package ☐ Hidradenitis Suppurativa (H.S.) Starter Package ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.8 mL Prefilled Syringe	**Psoriasis/Uveitis Induction Dose:** ☐ Inject two 40mg pens/syringes SC on day 1, then one 40mg pens/syringes on day 8, then one 40mg pens/syringes every other week (**NO REFILLS**)	4	X
		Psoriasis/Uveitis Maintenance Dose: ☐ Inject one 40 mg pen/syringe SC every other week		
		Hidradenitis Suppurativa Induction Dose: ☐ Inject four 40 mg pens/syringes SC on day 1, then two 40 mg pens/syringes on day 15, then one 40mg pens/syringes every week starting day 29 (**NO REFILLS**)	4	X
		Hidradenitis Suppurativa Induction ALT Dose: ☐ Inject two 40 mg pens/syringes SC on day 1, 2, 15, and then on day 29, one 40 mg pen every week (**NO REFILLS**)	4	X
		Hidradenitis Suppurativa Maintenance Dose: ☐ Inject one 40 mg pen/syringe SC every week		
☐ **Humira Citrate Free**	**Citrate Free** Starting Therapy ***Psoriasis/Uveitis Starter Package*** ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL Pen ☐ ***Hidradenitis Suppurativa (H.S.) Starter Package*** 80 mg/0.8 mL Pen ***Maintenance*** ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Prefilled Syringe	**Psoriasis Psoriasis Citrate Free Induction Dose:** ☐ Inject two 40 mg pens SC on day 1, then inject one 40 mg pen SC on day 8, then inject one 40 mg pen SC on day 22 or ☐ One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22	☐ 3 Pens ☐ 4 Syringes	
		Psoriasis Citrate Free Maintenance Dose: ☐ Inject one 40 mg pen/syringe SC every other week		
		Hidradenitis Suppurativa Citrate Free Induction Dose: ☐ Inject two 80 mg pen SC on day 1, then inject one 80 mg pen SC on day 15 or ☐ One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15	3	No Refills
		Hidradenitis Suppurativa Citrate Free Maintenance Dose: ☐ Inject one 40 mg pen/syringe SC day 29 & every other week		
☐ **Stelara**	☐ 45 mg/0.5 mL Prefilled Syringe	☐ **Induction Dose:** For patients weighing < 100 kg (220 lbs): Inject 45 mg SC on day 1 (**NO REFILLS**)	1	X
		☐ **Maintenance Dose:** For patients weighing < 100 kg (220 lbs): Inject 45 mg SC on day 29, then every 12 weeks		
Weight ________	☐ 90 mg/mL Prefilled Syringe	☐ **Induction Dose:** For patients weighing > 100 kg (220 lbs): Inject 90 mg SC on day 1 (**NO REFILLS**)	1	X
		☐ **Maintenance Dose:** For patients weighing > 100 kg (220 lbs) Inject 90 mg SC on day 29, then every 12 weeks		
☐ **Tremfya**	☐ 100 mg/1 mL Prefilled Syringe	**Psoriatic Arthritis Dose:** ☐ Inject SC one 100 mg injections at week 0 & week 4 thenevery 8 weeks thereafter		
☐ **Otezla**	☐ Titration Starter Pack **(4-week supply)**	☐ **Starter Dose:** Day 1: 10 mg in AM Day 2: 10 mg PO in AM & 10 mg PO in PM Day 3: 10 mg PO in AM & 20 mg PO in PM Day 4: 20 mg PO in AM & 20 mg PO in PM Day 5: 20 mg PO in AM & 30 mg PO in PM Day 6+: 30 mg PO TWICE daily	55 (28 Day Supply)	X
	☐ 30mg tablet	☐ **Maintenance Dose:** 1 tablet twice daily		
		☐ **Maintenance Dose (severe renal impairment):** Take 30 mg PO **ONCE** daily		
☐ **Other:**	☐ **Other:**	☐ **Other:**		

Quality Specialty Pharmacy

Physician Signature: ____________________ Date: ____________

***Prescription is VOID if the Number of drugs prescribed is NOT noted.** ________ ☐ **1** ☐ **2** ☐ **3**

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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