Add Logo

E-prescribe the *Fast & Easy* way: select **(Add company name)** from your EHR!

DERMATOLOGY REFERRAL FORM

Fax: (000) 000-0000
Phone: (000) 000-0000

PATIENT INFORMATION

Patient Name:	SSN:		DOB:	Height:
Address:	City:	State:	Zip:	Weight:
Home Phone:	Cell:	Email:	Gender: ◯ Male ◯ Female	

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Primary Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐Alopecia Areata ☐Other: _____ **Diagnosis Code(ICD-10):**_____

Date of Diagnosis:	TB Test Completed On:	BSA:	Latex Allergy: ◯ Y ◯ N

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

ADBRY™ *(tralokinumab-ldrm)* 150 mg Prefilled Syringe
☐ **Induction:** Inject 600 mg (4x150 mg) SubQ
Qty: 4 **Refills:** None
Maintenance:
☐ Inject 300 mg (2 x150 mg) SubQ every other week
☐ Inject 300 mg (2 x150 mg) SubQ every 4 weeks

☐ **ADBRY™ Bridge Care™** Program:
Inject 300 mg (2x 150 mg) SubQ every other week starting on Day 15
Qty: ☐ **Refills:** ☐

CIBINQO™ *(abrocitinib)* Tablet
☐ 50 mg ☐ 100 mg ☐ 200 mg
_____ mg PO once daily
Qty: ☐ **Refills:** ☐

Cimzia® *(certolizumab pegol)* Prefilled Syringe
☐ **Induction:** Inject 2 x 200 mg/ ml SubQ at week 0, 2 and 4
Qty: 6 syringes **Refills:** 0
Maintenance:
☐ 2 x 200 mg SubQ every 4 weeks
☐ 2 x 200 mg SubQ every 2 weeks
☐ 200 mg SubQ every 2 weeks
Qty: 28 days **Refills:** ☐

COSENTYX® *(secukinumab)*
☐ 150 mg Sensoready® Pen Kit
☐ 75 mg Prefilled Syringe Kit ☐ 150 mg Prefilled Syringe Kit
Induction:
☐ Inject 300 mg (2 x 150 mg/ ml) SubQ week 0, 1, 2, 3, 4
Qty: 10 Refills: 0
☐ Inject 150 mg SubQ week 0, 1, 2, 3, 4
Qty: 5 **Refills:** ☐
Maintenance:
☐ Inject 300 mg SubQ every 4 weeks
☐ Inject 150 mg SubQ every 4 weeks
Qty: 28 days **Refills:** ☐
☐ **Bridge***

DUPIXENT® *(dupilumab)* ☐ Prefilled Syringe ☐ Pen
☐ **Induction:** Inject 2 x 300 mg (600 mg) SubQ Day 1
Qty: 2 for 14 days **Refills:** None
☐ **Maintenance:** Inject 300 mg SubQ every other week
Qty: 2 for 28 days **Refills:** ☐

ENBREL® *(etanercept)*
☐ Mini Cartridge ☐ Prefilled Syringe ☐ AutoInjector ☐ Vial
☐ **Induction:** Inject (50 mg) SubQ twice weekly for three months
Qty: 8 **Refills:** 2
Maintenance:
☐ 50 mg ☐ 25 mg
☐ Once weekly SubQ ☐Twice weekly SubQ
Qty: ☐ 8 ☐ 4 **Refills:** ☐

ERIVEDGE™ *(vismodegib)* capsule 150 mg Once daily PO with or without food
Qty: 28 **Refills:** ☐

HUMIRA® *(adalimumab)*
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free(CF) ☐ Original Formula
Hidradenitis Suppurativa Starter:
☐ 160 mg SubQ day 1/ 80 mg SubQ day 15
☐ 80 mg SubQ day 1/ 80 mg SubQ day 2/ 80 mg SubQ day 15
☐ ***Psoriasis Starter:***
80 mg SubQ day 1, 40 mg SubQ day 8, 40 mg SubQ day 22
Qty: 1 Pack **Refills:** 0
☐***Hidradenitis Suppurativa Maintenance:***
☐ 40 mg SubQ once weekly, beginning day 29
☐ 80 mg SubQ every other week, beginning day 29
☐ ***Psoriasis Maintenance:***
40 mg SubQ every other week
Qty: 28 days **Refills:** ☐

INFLECTRA® *(infliximab-dyyb)* 100 mg vials
☐3 mg/ kg ☐ 5 mg/ kg ☐ 10 mg/ kg
☐ **Induction:** Give dose as an IV infusion at 0, 2, and 6 weeks
Qty: ☐ **Refills:** 2
☐**Maintenance:** Give dose as an IV infusion every __ weeks
Qty: ☐ **Refills:** 2

ILUMYA™ *(tildrakizumab-asmn)* Prefilled Syringe
☐ **Induction:** Inject 100 mg/ml SubQ at weeks 0 and 4
Qty: 2 **Refills:** None
☐**Maintenance:** Inject 100 mg/ml SubQ every 12 weeks
Qty: ☐ **Refills:** ☐

ODOMZO® *(sonidegib)* capsule 200 mg on an empty stomach, at least 1 hr before or 2 hours after a meal
Qty: 30 **Refills:** ☐

OLUMIANT® *(baricitinib)* tablets
☐ 2 mg PO once daily ☐ 4 mg PO once daily
Qty: ☐ **Refills:** ☐

OTEZLA® *(apremilast)*
☐ **Titration Pack:**
PO as directed per package instructions
Qty: 1 Pack **Refills:** 0
☐ **Bridge Pack:**
PO as directed per package instructions
Qty: 1 Pack **Refills:** ☐
☐ **Maintenance:** (30 mg) PO twice daily
Qty: 30 days **Refills:** ☐

REMICADE® *(infliximab-dyyb)* 100 mg vials ☐ Biosimilar authorized
☐ **Induction:** 5 mg/ kg as an IV infusion at 0, 2, and 6 weeks
Qty: 1 dose Refills: 2
☐**Maintenance:** 5 mg/ kg as an IV infusion every 8 weeks
Qty: ☐ **Refills:** ☐

RINVOQ® *(upadacitinib)* extended-release tablets
☐ 15 mg ☐ 30 mg
Once daily PO with or without food
Qty: ☐ **Refills:** ☐

SIMPONI® *(golimumab)*
☐ Prefilled Syringe ☐Autoinjector
☐ Inject 50 mg SubQ once a month
Qty: 1 **Refills:** ☐

SILIQ® *(brodalumab)* Prefilled Syringe
☐ **Induction:** Inject 210 mg SubQ weeks 0 and 1
Qty: 2 **Refills:** 0
☐ **Maintenance:** Starting at Week 2 of therapy, inject 210 mg SubQ every two weeks
Qty: 2 **Refills:** ☐

SKYRIZI™ *(risankizumab-rzaa)*
☐ Prefilled Syringe ☐ Pen
☐ Inject 150 mg (1 injection) SubQ at Week 0, Week 4
Qty: 2 **Refills: None**
☐ **Maintenance:** Inject 150 (1 injection) SubQ every 12 weeks
Qty: ☐ **Refills:** ☐

STELARA® *(ustekinumab)*
☐ 45 mg Prefilled Syringe ☐ 90 mg Prefilled Syringe
☐ **Induction:**
Inject contents of 1 syringe SubQ on day 0 and day 28
Qty: 1 syringe **Refills**: 1
☐ **Maintenance:**
Inject contents of 1 syringe SubQ every 12 weeks
Qty: 1 syringe **Refills:** ☐

SOTYKTU™ *(deucravacitinib)* 6 mg tablet
Once daily PO with or without food
Qty: ☐ **Refills:** ☐

TALTZ® CF *(ixekizumab)*
☐AutoInjector ☐ Prefilled Syringe
☐ ***Psoriasis Induction:*** Inject 160 mg (2 x 80 mg) SubQ at week 0; Inject CF80 mg at weeks 2, 4, 6, 8, 10, 12
Qty: 8 **Refills:** 0
☐ ***Psoriatic Arthritis Induction:*** Inject 160 mg (2 x 80 mg) SubQ at week 0
Qty: 2 **Refills:**0
☐ **Maintenance:** 80 mg SubQ every 4 weeks
Qty: 1 **Refills:** ☐

TREMFYA® *(guselkumab)* ☐ Prefilled Syringe ☐ AutoInjector
☐ **Induction:** Inject 100 mg SubQ weeks 0 and 4
Qty: 1 **Refills:** 1
☐ **Maintenance:** Inject 100 mg SubQ every 8 weeks
Qty: 1 **Refills:** ☐

☐ OTHER	STRENGTH:	SIG/DIRECTIONS:	Refills:	QUANTITY:

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		Ship To: ☐ Patient ☐ MD Office
NPI #:	Tax ID#:	
Prescription Signature:		Date:

Your signature authorizes (add company name) Pharmacy Services,LLC, and their network of pharmacies, to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients.