

DERMATOLOGY REFERRAL FORM

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Patient Information

Patient Name: _____ DOB: _____ Sex: M F
 Phone: _____ Cell Phone: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ICD-10 Diagnosis Code: _____ Diagnosis: _____
 Allergies (please note reaction): _____ Latex
 Current Medications: (list here or attach a medication list): _____
 Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Cimzia (certolizumab)	<input type="checkbox"/> Starter Kit 200mg/mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 400mg (2 syringes) subcutaneously at weeks 0, 2 and 4.	1 kit (6 syringes)	
	<input type="checkbox"/> 200mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 400mg (2 syringes) subcutaneously every 4 weeks. <input type="checkbox"/> Maintenance Dose: Inject 200mg (1 syringe) subcutaneously every 2 weeks.	28-day supply	
<input type="checkbox"/> Cosentyx (secukinumab)	<input type="checkbox"/> 150mg Sensoready Pen	<input type="checkbox"/> Loading Dose: Inject 150mg subcutaneously once weekly at weeks 0, 1, 2, 3, and 4. <input type="checkbox"/> Loading Dose: Inject 300mg (2 injections of 150mg) subcutaneously once weekly at weeks 0, 1, 2, 3, and 4.	5 doses	
	<input type="checkbox"/> 150mg Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 150mg subcutaneously every 4 weeks. <input type="checkbox"/> Maintenance Dose: Inject 300mg (2 injections of 150mg) subcutaneously every 4 weeks.	28-day supply	
<input type="checkbox"/> Dupixent (dupilumab)	<input type="checkbox"/> 300mg/2mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 600mg (given as two 300mg injections in different sites) subcutaneously one time.	2 Syringes	
		<input type="checkbox"/> Maintenance Dose: Inject 300mg subcutaneously every other week.	28-day supply	
<input type="checkbox"/> Enbrel (etanercept)	<input type="checkbox"/> 50mg/mL Sureclick Auto-injector	<input type="checkbox"/> Loading Dose: Inject 50mg subcutaneously twice a week (72-96 hours apart) for 3 months.	28-day supply	
	<input type="checkbox"/> 50mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 50mg subcutaneously once a week.	28-day supply	
<input type="checkbox"/> Humira (adalimumab)	<input type="checkbox"/> Citrate-free Psoriasis Starter Kit (3 pens)	<input type="checkbox"/> Plaque Psoriasis (adult) or Hidradenitis Suppurativa (12 years and older, 30 kg to < 60 kg) Loading Dose: Inject 80mg subcutaneously on day 1, then 40mg on day 8, then 40mg on day 22 and every OTHER week thereafter.	1 kit	
	<input type="checkbox"/> Psoriasis Starter Kit (4 pens)			
	<input type="checkbox"/> Citrate-free Hidradenitis Suppurativa Starter Kit (3 pens)		<input type="checkbox"/> Hidradenitis Suppurativa (adult or 12 years and older, ≥ 60 kg) Loading Dose: Inject 160mg (two 80mg pens) subcutaneously on day 1, then 80mg (one 80mg pen) on day 15, then 40mg (one 40mg pen) on day 29 and once a week thereafter.	28-day supply
<input type="checkbox"/> Orencia (abatacept)	<input type="checkbox"/> 40mg/0.4 mL Citrate-free Pen	<input type="checkbox"/> Plaque Psoriasis (adult) or Hidradenitis Suppurativa (12 years and older, 30 kg to < 60 kg) Maintenance Dose: Inject 40mg subcutaneously on day 22 then every OTHER week thereafter. <input type="checkbox"/> Hidradenitis Suppurativa (adult or 12 years and older, ≥ 60 kg) Maintenance Dose: Inject 40mg subcutaneously on day 29 then once a week thereafter.	28-day supply	
	<input type="checkbox"/> 40mg/0.8 mL Pen			
	<input type="checkbox"/> 40mg/0.4 mL Citrate-free Prefilled Syringe			
	<input type="checkbox"/> 40mg/0.8 mL Prefilled Syringe			
<input type="checkbox"/> Orencia (abatacept)	<input type="checkbox"/> 250mg Vial (IV use only)	<input type="checkbox"/> Loading Dose: Administer ____ mg via intravenous infusion at 0, 2 and 4 weeks.	28-day supply	
	<input type="checkbox"/> 125mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Administer ____ mg via intravenous infusion every 4 weeks. <input type="checkbox"/> Inject 125mg subcutaneously once weekly.		
<input type="checkbox"/> Otezla (apremilast)	<input type="checkbox"/> 14-day Starter Pack	<input type="checkbox"/> Loading Dose: Take 10mg by mouth in the morning on day 1, then take 10mg twice daily on day 2, then take 10mg in the morning and 20mg in the evening on day 3, then take 20mg twice daily on day 4, then take 20mg in the morning and 30mg in the evening on day 5, then take 30mg twice daily on day 6 and thereafter. <input type="checkbox"/> Loading Dose (severe renal impairment, CrCL < 30mL/min): Take 10mg by mouth in the morning on days 1, 2 and 3; then take 20mg in the morning on days 4 and 5; then take 30mg in the morning on day 6 and thereafter.	1 pack	
	<input type="checkbox"/> 28-day Starter Pack			
	<input type="checkbox"/> 30mg Tablet		<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth twice daily.	60
		<input type="checkbox"/> Maintenance Dose (severe renal impairment, CrCL < 30mL/min): Take 1 tablet by mouth once daily.	30	

Prescription information continued on next page

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Remicade (infliximab)	100mg Vial	Loading Dose: Administer ____ mg (at 5 mg/kg) intravenously at 0, 2 and 6 weeks.	42-day supply	
<input type="checkbox"/> Inflectra (infliximab-dyyb)		Maintenance Dose: Administer ____ mg (at 5mg/kg) intravenously every ____ weeks.	28-day supply	
<input type="checkbox"/> Siliq (brodalumab)	<input type="checkbox"/> 210mg/1.5mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 210mg (1 syringe) subcutaneously at weeks 0, 1 and 2, then every 2 weeks thereafter.	28-day supply (4 syringes)	
		<input type="checkbox"/> Maintenance Dose: Inject 210mg (1 syringe) subcutaneously every 2 weeks.	28-day supply	
<input type="checkbox"/> Simponi (golimumab)	<input type="checkbox"/> 50mg/0.5mL SmartJect Auto-injector <input type="checkbox"/> 50mg/0.5mL Prefilled Syringe	<input type="checkbox"/> Inject 50mg subcutaneously once a month.	28-day supply	
<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> 45mg/0.5mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject the contents of 1 prefilled syringe subcutaneously on Day 1 and then repeat on Day 29.	28-day supply	
	<input type="checkbox"/> 90mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject the contents of 1 prefilled syringe subcutaneously every 12 weeks.	12-wk supply	
<input type="checkbox"/> Taltz (ixekizumab)	<input type="checkbox"/> 80mg/mL Auto-injector <input type="checkbox"/> 80mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 160mg subcutaneously at weeks 2, 4, 6, 8, 10 and 12; then inject 80mg subcutaneously every 4 weeks. <input type="checkbox"/> Inject 160mg subcutaneously once, followed by 80mg subcutaneously every 4 weeks. <input type="checkbox"/> Inject 80mg subcutaneously every 4 weeks.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply	
<input type="checkbox"/> Tremfya (guselkumab)	100mg/mL Prefilled Syringe	<input type="checkbox"/> Loading Dose: Inject 100mg (1 syringe) subcutaneously at weeks 0 and 4, then every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: Inject 100mg (1 syringe) subcutaneously every 8 weeks.	28-day supply 56-day supply	
Other Medication Name:				

Treatment History: **New to Therapy** **Continuation of Therapy**

Hepatitis B Screening Results: HBsAg: _____ Anti-HBs: _____ Anti-HBc: _____

If applicable, has treatment been initiated? Yes No

Tuberculosis Assessment Date: Negative Active TB Latent TB History of active or latent TB

If history of active or latent TB: _____ Adequate treatment is confirmed: Yes No

History of Irritable Bowel Disease: Yes No

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____
 Product Substitution Permitted Dispensed as Written Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____

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