DERMATOLOGY REFERRAL FORM

Across Specialty Pharmacy
PH (770) 746 0130 | FAX (770) 746 0131
NCPDP 1175288 | NPI 1275142614

First Dose Given By: ☐ Provider/Clinic ☐ Patient ☐ Home Health Date Shipment Needed:

PATIENT INFORMATION				DOCTOR INFORMATION INJECTION TRAINING: ☐ Office ☐ Specialty Pharmacy			
Patient Name:				Prescriber:			
Street Address:				NPI:		Specialty:	☐ Dermatologist ☐ Other _____
City, State, Zip:				Street Address:			
Phone #1:		Phone #2:		City, State, Zip:			
Height: _____	Weight: _____	Sex:	☐ Male ☐ Female	Office Phone:		Office Fax:	
Date of Birth:		Allergies:		Primary Contact:			
Comorbidities:				Email:			

INSURANCE INFORMATION

Insurance Plan Type:	Identification Number:
Processor Control No. (PCN): Rx BIN:	Rx Group:

PLEASE SEND PROGRESS NOTES FOR DOCUMENTATION

New Therapy ☐ Renewal Therapy If Renewal: Date Therapy Initiated:_____

Diagnosis ICD 10:_____ **Other:** _____
Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa
☐ TB test performed? ☐ Yes ☐ No Date of Neg. Test ☐ Yes ☐ No
☐ HBV ruled out? ☐ Yes ☐ No Does patient have active infection? ☐ Yes ☐ No

Does the patient have inadequate response to PUVA or UVB? ☐ Yes ☐ No
Location:
☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails
Other:_____ **BSA (% is required):** _____%

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Dose Directions	Refills
☐ Cimzia®	☐ Cimzia Starter Kit (6x200mg PFS) ☐ Prefilled Syringe x2 ☐ Vial x2	☐ **Initial:** Inject 400mg SQ at weeks 0, 2, and 4 ☐ **Maintenance:** Inject_____mg SQ every: ☐ 2 ☐ 4 wks. Qty_____	Refill:
☐ Cosentyx®	☐ 150mg/mL PEN ☐ 150mg/mL PFS	☐ **Initial:** Inject_____mg SQ at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance:** Inject_____mg SQ every 4 weeks Qty_____	Refill:
☐ Dupixent®	☐ 300mg/2mL ☐ Syringe ☐ 200mg/1.14ml ☐ Pen	☐ **Adult:** 600mg SQ on Day 1, then 300mg SQ every otherweek, starting on Day 15 ☐ **Pediatric:** _____mg SQ on Day 1,_____mg SQ every_____week, starting on Day_____ Qty_____	Refill:
☐ Enbrel®	☐ Mini Cartridge ☐ SureClick ☐ Prefilled Syringe ☐ Vial	☐ **Induction**: Inject (50 mg) SQ twice weekly for three months ☐ **Maintenance**:☐50 mg ☐ 25 mg ☐ Once weekly SQ ☐ Twice weekly SQ Qty: ☐ 8 ☐ 4	Refill:
☐ Ilumya®	☐ Prefilled Syringe	☐ Inject 100 mg/ml SQ at weeks 0, 4 and every 12 weeks thereafter Qty:_____	Refill:
☐ Humira® (Citrate Free)	☐ Pen ☐ Prefilled Syringe ☐ Citrate Free(CF) ☐ Original Formula	☐ **Hidradenitis Suppurativa Starter:** ☐ 160 mg SQ Day 1/ 80 mg SQ Day 15 ☐80 mg SQ Day 1/ 80 mg SQ Day 2/ 80 mg SQ Day 15 ☐ **Psoriasis Starter:** 80 mg SQ Day 1, 40 mg SQ Day 8, 40 mg SQ Day 22 Qty:__ Pack ☐ **Hidradenitis Suppurativa Maintenance:** 40 mg SQ once weekly, beginning Day 29 ☐ Psoriasis Maintenance:40 mg SQ every other week	Refill:
☐ Otezla®	☐ Titration Starter Pack Rx ☐ 30mg Tablet	☐ Take as directed *Only select for Titration Starter Pack* ☐ Take 30 mg PO ONCE daily ☐ Take 30 mg PO TWICE daily Qty:_____	Refill:
☐ Siliq®	☐ Prefilled Syringe	☐ **Induction**: Inject 210 mg SQ weeks 0 and 1 ☐ **Maintenance**:Starting at Week 2 of therapy, inject 210 mg SQ every two weeks Qty:_____	Refill:
☐ Skyrizi®	☐ 4 X 75 mg/0.83mL Prefilled Syringe	☐ Inject 150 mg (2x75mg syringes) SQ at week 0, 4 every 12 weeks thereafter Qty:_____	
☐ Stelara®	☐ 45mg/0.5mL PFS ☐ 90mg/mL PFS	☐ **Initial:** Inject contents of 1 PFS SQ on day 0 and day 28 ☐ **Maintenance:** Inject contents of 1 PFS SQ every 12 weeks Qty:_____	Refill:
☐ Taltz®	☐ 80mg/mL PFS ☐ 80mg/mL Autoinjector	☐ **Initial:** Inject 160mg (two 80mg injections) at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10, and 12, then 80mg every 4 weeks ☐ **Maintenance:** Inject 80mg SQ every 4 weeks Qty:_____	Refill:
☐ Tremfya®	☐ 100mg/mL PFS ☐ 100mg/mL Autoinjector	☐ Inject 100mg SQ at week 0, 4, and every 8 weeks there after ☐ Inject 100mg SQ every 8 weeks Qty:_____	Refill:
☐ Xeljanz / Xeljanz XR	☐ 5MG (60 tabs) ☐ 11MG (30 tabs)	☐ 5mg twice daily (Xeljanz) ☐ 11MG once daily (Xeljanz XR) Qty:_____	

OTHER:	STRENGTH:	SIG/DIRECTIONS:	QUANTITY:	REFILL

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____