Date Shipment Needed: _____ Ship To: ☐Patient ☐Prescriber
☐Nursing needed; ☐Training needed ► All the supplies including syringes and needles will be dispensed if needed.

S-Z DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION					
Patient Name:	DOB:	Sex: ☐M ☐F ☐Other:		Weight:	☐lbs. ☐kg.
SSN: Phone:	Allergies:				
Address:	City:	State:	Zip:		
Emergency Contact:	Phone:	☐**Additional Information Attached**			

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐L28.1 Prurigo nodularis ☐L40.0 Psoriasis ☐L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis ☐L40.59 ☐L50.1 Chronic Idiopathic Urticaria ☐L73.2 Hidradenitis Suppurativa ☐Other: _____

- Location: ☐Hands ☐Feet ☐Face ☐Scalp ☐Groin ☐Nails ☐Others: _____
- Severity: ☐Mild (up to 3% BSA) ☐Moderate (3-10% BSA) ☐Severe (*greater than* 10% BSA), BSA _____%

If treated previously for this condition, please indicate which drugs have been tried and failed: _____

Date range of previous therapy: _____

- Is patient currently on therapy? ☐Yes ☐No Type/ medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No, if yes, how long should patient wait before starting the new medication? _____
- Has patient received a PPD (tuberculosis) Skin Test? ☐Yes ☐No Results: _____
  Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

PRESCRIPTION INFORMATION

☐**STC Standard Protocol** will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and/or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Siliq® ☐ 210 mg/1.5 mL Prefilled Syringe (2 pack) — ☐**Enroll in REMS Program**
- ☐ Starter Dose for Plaque Psoriasis: 210 mg SQ at weeks 0, 1 and 2, followed by maintenance dose — QTY: 1 box (2 PFS) Refills: 0
- ☐Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks. (starting at week 2) — QTY: 1 box (2 PFS) Refills:

Simponi® ☐ Aria 50 mg/4 mL Patient weight (kg): _____ — ☐**Enroll in SimponiOne® Program**
- ☐Starter Dose: 2 mg/kg IV at weeks 0 and 4 — QTY: 1 month Refills: 0
- ☐Maintenance Dose: 2 mg/kg IV every 8 weeks — QTY: QS for 8 weeks Refills:

Simponi® ☐SmartJect 50 mg/0.5 mL ☐Prefilled Syringe 50 mg/0.5 mL *Pens will be dispensed if no preference is indicated
- ☐ 50 mg SQ every month — QTY: 1 month Refills:
- ☐ Other: _____ — QTY: Refills:

Skyrizi® ☐Pen autoinjector 150mg/mL ☐Prefilled syringe 150mg/ml *Pens will be dispensed if no preference is indicated
- ☐ Starter dose: 150 mg SQ at Week 0 and 4 — QTY: 1 Refills: 0
- ☐ Maintenance Dose: 150 mg SQ every 12 Weeks — QTY: 1 Refills:

Sotyku® ☐6mg po once daily — QTY: Refills:

Stelara® ☐Prefilled Syringe ☐Vial ☐MD's Office Infusion ☐Home Infusion Supplies Required *Prefilled syringe will be dispensed if preference is not indicated — ☐Enroll in Janssen CarePath Program
- ☐≤ 100 kg Starter Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 Weeks of initial dose (week 4) — QTY: 1 x 45mg Refills: 1
- ☐≤ 100 kg Maintenance Dose: 45 mg SQ every 12 Weeks ☐Other_____ — QTY: 1 x 45mg Refills:
- ☐> 100 kg Starter Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 Weeks of initial dose (week 4) — QTY: 1 x 90mg Refills: 1
- ☐> 100 kg Maintenance Dose: 90 mg SQ every 12 Weeks ☐Other_____ — QTY: 1 x 90mg Refills:

Taltz® ☐Autoinjector 80 mg/mL ☐Prefilled Syringe 80 mg/mL *Pens will be dispensed if no preference is indicated
- ☐Starter Dose for Plaque Psoriasis: 160 mg (two 80 mg inj.) at Week 0, then 80 mg at Week 2,4,6,8,10,12 — QTY: 8 Refills: 0
- ☐Maintenance Dose for Plaque Psoriasis: 80 mg every 4 weeks — QTY: 1 Refills:
- ☐Starting Dose for Psoriatic Arthritis: 160 mg (two 80 mg inj.) at Week 0 — QTY: 2 Refills: 0
- ☐Maintenance Dose for Psoriatic Arthritis: 80 mg every 4 Weeks — QTY: 1 Refills:
- ☐Other_____ — QTY: Refills:

Tremfya® ☐Pen autoinjector 100 mg/mL ☐Prefilled syringe 100 mg/mL *Pen will be dispensed if no preference is indicated
- ☐Starter Dose: 100 mg SQ at Week 0, 4, and every 8 Weeks thereafter — QTY: 1 Refills: 0
- ☐Maintenance Dose: 100 mg SQ every 8 Weeks (starting at week 4) — QTY: 1 Refills:

Xeljanz® ☐5mg tablet ☐10mg tablet ☐11mg ER tablet
- ☐1 tablet po twice daily — QTY: 1 month Refills:

Xolair® ☐Prefilled Syringe 150 mg ☐ Vial 150 mg
- ☐150mg SQ every 4 weeks ☐300mg SQ every 4 weeks — QTY: 28 day supply Refills:

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. Prescriber authorizes receiving pharmacy to forward this prescription to another pharmacy, if needed.