AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

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

DERMATOLOGY REFERRAL FORM (A - D)

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: ☐ L20, L20.8, L20.9 Atopic Dermatitis ☐ 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 ☐ Other: _____
- 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.

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

Adbry ® ☐ **150 mg Prefilled Syringe**

	☐ *Starter Dose:* 600 mg SQ on Day 1	☐ Starter Dose not needed	QTY: #4 Syringes / 14 DS | Refills: 0
After 16 wks of treatment	☐ *Maintenance Dose:* 300 mg SQ every 4 weeks		QTY: #2 Syringes / 28 DS | Refills:
	☐ *Maintenance Dose:* 300 mg SQ every other week		QTY: #4 Syringes / 28 DS | Refills:

Adbry ® ☐ **300 mg Pen**

	☐ *Starter Dose:* 600 mg SQ on Day 1	☐ Starter Dose not needed	QTY: #2 Pens / 14 DS | Refills: 0
After 16 wks of treatment	☐ *Maintenance Dose:* 300 mg SQ every 4 weeks		QTY: #1 Pens / 28 DS | Refills:
	☐ *Maintenance Dose:* 300 mg SQ every other week		QTY: #2 Pens / 28 DS | Refills:

Adbry ® ☐ **150 mg Prefilled Syringe** (***Pediatric:*** *12 years and older)*

	☐ *Starter Dose:* 300 mg SQ on Day 1	☐ Starter Dose not needed	QTY: #2 Syringes / 14 DS | Refills: 0
	☐ *Maintenance Dose:* 150 mg SQ every other week		QTY: #2 Syringes / 28 DS | Refills:

Bimzelx® ☐ **160 mg / mL Pen** *OR* ☐ **160 mg / mL Syringe**

☐ 320 mg (given as two 160 mg injections) SQ every 4 weeks for the first 16 weeks	QTY: 2 | Refills: 4
☐ 320 mg (given as two 160 mg injections) SQ every 8 weeks	QTY: 2 | Refills:

Cibinqo® ☐ **50 mg Tablet** ☐ **100 mg Tablet** ☐ **200 mg Tablet**
☐ 1 tablet PO once daily ☐ Other: _____ QTY: 1 Month \| Refills:

Cimzia® ☐ **200 mg Vial** ☐ **200 mg / mL Prefilled Syringe**
☐ 400 mg / mL SQ every 2 weeks
☐ 400 mg SQ at Weeks 0, 2, 4, then 200 mg every other week thereafter (patient ≤ 90 kg) QTY: 1 Month \| Refills:

Cosentyx® ☐ **150 mg / mL Sensoready® Pen** ☐ **150 mg / mL Prefilled Syringe** ☐ **300 mg UnoReady Pen**
**Sensoready® Pen will be dispensed if no preference indicated*

☐ *Starter Dose:* 300 mg SQ initially (Weeks 0, 1, 2, 3 and 4) then 300 mg SQ every 4 weeks thereafter (Week 4)	☐ Starter Dose not needed	QTY: 5 Weeks | Refills: 0
☐ *Maintenance Dose:* 300 mg SQ every 4 weeks		QTY: 1 Month | Refills:
☐ Other: _____		QTY: 1 Month | Refills:

Dupixent® (*Dupilumab*) ☐ **200 mg Pen Autoinjector** ☐ **200 mg Prefilled Syringe** ☐ **300 mg Pen Autoinjector** ☐ **300 mg Prefilled Syringe**
**Pen will be dispensed if no preference indicated for adult dosing. Prefilled Syringe may be used in ages ≥ 6 months. Prefilled Pen is only for use in ages ≥ 2 years.*

Adults:	☐ *Starter Dose:* Inj. 600 mg SQ on Day 1, then 300 mg SQ every 2 weeks starting on Day 15	☐ Starter Dose not needed	QTY: QS for Starter | Refills: 0
	☐ *Maintenance Dose:* Inj. 300 mg SQ every 2 Weeks		QTY: 1 Month | Refills:

Infants & Children: ≥ 6 mo - < 6 yrs: Initial loading dose not necessary in pediatric patients < 6 yrs.
☐ 5 to < 15 kg: Dupixent 200 mg SQ every 4 weeks ☐ 15 to < 30 kg: Dupixent 300 mg SQ every 4 weeks QTY: 1 Box: 2 Pens / Syringes \| Refills:

Children & Adolescents: ≥ 6 years - ≤ 17 years:

☐ 15 to < 30 kg: *Initial:* 600 mg SQ once (administered as two 300 mg injections)	QTY: 1 Box: 2 Pens / Syringes | Refills: 0
☐ 15 to < 30 kg: *Maintenance:* 300 mg SQ every 4 weeks	QTY: 1 Box: 2 Pens / Syringes | Refills:
☐ 30 to < 60 kg: *Initial:* 400 mg SQ once (administered as two 200 mg injections)	QTY: 1 Box: 2 Pens / Syringes | Refills: 0
☐ 30 to < 60 kg: *Maintenance:* 200 mg SQ every other week	QTY: 1 Box: 2 Pens / Syringes | Refills:
☐ ≥ 60 kg: *Initial:* 600 mg SQ once (administered as two 300 mg injections)	QTY: 1 Box: 2 Pens / Syringes | Refills: 0
☐ ≥ 60 kg: *Maintenance:* 300 mg SQ every other week	QTY: 1 Box: 2 Pens / Syringes | 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. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

DERMATOLOGY REFERRAL FORM (E - K)

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: ☐ L20, L20.8, L20.9 Atopic Dermatitis ☐ 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 ☐ Other: _____
- 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.

INSURANCE INFORMATION

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COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

Ebglyss™ ☐ **250 mg / 2 mL Pen** ☐ **250 mg / 2 mL Prefilled Syringe**

☐ *Starter Dose:* 500 mg (2 injections) SQ at Weeks 0 and 2 — ☐ Starter Dose not needed — QTY: QS 28 DS | Refills: 0
☐ *Maintenance Dose:* 250 mg (1 injection) SQ every 2 weeks until Week 16 or later — QTY: QS 84 DS | Refills:
☐ *Optional:* 250 mg (1 injection) SQ every 4 weeks — QTY: QS 28 DS | Refills:

Enbrel® ☐ **50 mg / mL SureClick (Autoinjector)** ☐ **50 mg Prefilled Syringe** ☐ **Mini 50 mg Cartridge** **SureClick will be dispensed if no preference indicated* — ☐ **Enroll in Enliven® Program**

☐ *Starter Dose:* 50 mg SQ twice weekly (72 - 96 hours apart) for 3 months — ☐ Starter Dose not needed — QTY: 1 Month | Refills: 2
☐ *Maintenance Dose:* 50 mg SQ weekly ☐ Other: _____ — QTY: 1 Month | Refills:

Enbrel® ☐ **25 mg / 0.5 mL Prefilled Syringe** ☐ **25 mg Single-Use Vial** **Prefilled Syringe will be dispensed if no preference indicated*

☐ 25 mg SQ twice weekly (72 - 96 hours apart) ☐ Other: _____ — QTY: 1 Month | Refills:

Erivedge® ☐ **150 mg Capsules** Take 1 capsule orally once daily — QTY: 28 Capsules | Refills:

Humira® ☐ **CF Pen Psoriasis Starter Kit** *NDC: 0074-1539-03* ☐ **CF 40 mg / 0.4 mL Prefilled Syringe** *NDC: 0074-0243-02* — ☐ **Enroll in Humira Complete Program**
**Pen Starter Kit will be dispensed if no preference indicated*

☐ *Starter Dose for Psoriasis:* ☐ One 80 mg SQ inj. **Day 1**, one 40 mg SQ inj. **Day 8**, one 40 mg SQ inj. **Day 22** *(OR)* ☐ Two 40 mg SQ inj. **Day 1**, one 40 mg SQ inj. **Day 8**, one 40 mg SQ inj. **Day 22** — ☐ Starter Dose not needed — QTY: 3 Pens | Refills: 0 ; QTY: 4 Syringes | Refills: 0

Humira® ☐ **CF 40 mg / 0.4 mL Pen** *NDC: 0074-0554-02* ☐ **CF 40 mg / 0.4 mL Syringe** *NDC: 0074-0243-02*
**Pen will be dispensed if no preference indicated*

☐ *Maintenance Dose for Psoriasis:* 40 mg SQ once every other week — QTY: 1 Month | Refills:

Humira® ☐ **Starter Pkg CF 80 mg / 0.8 mL Pen** *NDC: 0074-0124-03* ☐ **CF 40 mg / 0.4 mL Prefilled Syringe** *NDC: 0074-0243-02*
**Pen will be dispensed if no preference indicated*

☐ *Starter Dose for Hidradenitis Suppurativa:* ☐ Inj. 160 mg SQ Day 1, then 80 mg SQ Day 15 *(OR)* ☐ Inj. 80 mg SQ Day 1, and 80 mg SQ Day 2, then 80 mg SQ Day 15 — ☐ Starter Dose not needed — QTY: 1 Month | Refills: 0 ; QTY: 1 Month | Refills: 0

Humira® ☐ **CF 40 mg / 0.4 mL Pen** *NDC: 0074-0554-02* ☐ **CF 40 mg / 0.4 mL Syringe** *NDC: 0074-0243-02*
**Pen will be dispensed if no preference indicated*

☐ *Maintenance Dose for Hidradenitis Suppurativa:* 40 mg SQ Day 29 and every week thereafter — QTY: 1 Month | Refills:
☐ Other: _____ — QTY: | Refills:

Ilumya® ☐ **100 mg / mL Prefilled Syringes**

☐ *Starter Dose:* 100 mg SQ on Week 0 and Week 4 — ☐ Starter Dose not needed — QTY: 1 Month (1 PFS) | Refills: 0
☐ *Maintenance Dose:* 100 mg SQ every 12 weeks (starting at Week 4) — QTY: 1 Syringe | Refills:

Kevzara® *(Sarilumab)* ☐ **200 mg / 1.14 mL Pen Autoinjector** ☐ **200 mg / 1.14 mL Prefilled Syringe** **Pens will be dispensed if no preference is indicated*

☐ 200 mg subcutaneously every 2 Weeks — QTY: 1 Box (2) | 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. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
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DERMATOLOGY REFERRAL FORM (L - Sil)

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: ☐ L20, L20.8, L20.9 Atopic Dermatitis ☐ 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 ☐ Other: _____
- 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.

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

Nemluvio® ☐ **30 mg Pen** - *The recommended subcutaneous dosage of NEMLUVIO for adult patients weighing less than 90 kg is an initial dose of 60 mg (two 30 mg injections), followed by 30 mg given every 4 weeks (Q4W)*
Adult Patients Weighing less than 90 kg: ☐ Inject 60 mg SQ once for initial dose — QTY: #2 Pens/28 DS | Refills: 0
☐ Inject 30 mg SQ every 4 weeks — QTY: #1 Pens/28 DS | Refills:

Nemluvio® ☐ **60 mg Pen** - *The recommended subcutaneous dosage of NEMLUVIO for adult patients weighing 90 kg or more is an initial dose of 60 mg (two 30 mg injections), followed by 60 mg given every 4 weeks (Q4W)*
Adult Patients Weighing 90 kg or more: ☐ Inject 60 mg SQ once for initial dose — QTY: #2 Pens/28 DS | Refills: 0
☐ Inject 60 mg SQ every 4 weeks — QTY: #2 Pens/28 DS | Refills:

Odomzo® ☐ **200 mg Capsule PO Once Daily** — QTY: 30 CAPS | Refills:

Otezla® Tablets Plaque Psoriasis - *moderate to severe;* **Note:** *Initial dose titration is intended to reduce GI symptoms*
— ***Adults*:**
☐ *Titration Dose:* **DAY 1**: 10 mg in morning; **DAY 2:** 10 mg in morning & 10 mg in evening; **DAY 3:** 10 mg in morning & 20 mg in evening; **DAY 4**: 20 mg in morning & 20 mg in evening; **DAY 5:** 20 mg in morning & 30 mg in evening; **DAY 6 & thereafter:** 30 mg twice daily — QTY: 1 Month | Refills: 0
☐ *Maintenance Dose:* 30 mg twice daily — QTY: 60 TABS (30 mg) | Refills:
☐ Other: _____ — QTY: | Refills:

— ***Children & Adolescents:*** ≥ 6 years weighing 20 to < 50 kg:
☐ **Otezla® 28 Day Treatment Initiation Pack: DAY 1**: Oral: 10 mg once daily in the morning; **DAY 2:** Oral: 10 mg twice daily; **DAY 3:** Oral: 10 mg in the morning & 20 mg in the evening; **DAY 4 & therafter:** Oral: 20 mg twice daily — QTY: # 1 | Refills: 0
☐ **Otezla® 20 mg Tablet:** Take 20 mg PO twice daily — QTY: 60 TABS | Refills:

— ***Children & Adolescents:*** ≥ 6 years weighing ≥ 50 kg:
☐ **Otezla® 28 Day Treatment Initiation Pack: DAY 1**: Oral: 10 mg once daily in the morning; **DAY 2:** Oral: 10 mg twice daily; **DAY 3:** Oral: 10 mg in the morning & 20 mg in the evening; **DAY 4:** Oral: 20 mg twice daily; **DAY 5:** Oral: 20 mg in the morning & 30 mg in the evening; **DAY 6 & therafter:** Oral: 30 mg twice daily — QTY: # 1 | Refills: 0
☐ **Otezla® 30 mg Tablet:** Take 30 mg PO twice daily — QTY: 60 TABS | Refills:

☐ **Remicade®** 100 mg Vial ☐ **Inflectra®** 100 mg Powder Vial ☐ **Renflexis®** 100 mg Powder Vial ☐ **Avsola®** 100 mg Powder Vial — ☐ **Enroll in AccessOneSM Program**
☐ MD's Office Infusion ☐ Home Infusion Supplies Required ☐ Starter Dose not needed
☐ *Starter Dose:* _____ mg IV on Week 0, Week 2, Week 6, then — QTY: QS 3 Infusions | Refills: 0
☐ *Maintenance Dose:* _____ mg IV every _____ weeks — QTY: QS 1 Infusion | Refills:

Rinvoq® ☐ **15 mg Tablet** ☐ **30 mg Tablet** Take 1 tablet PO once daily — QTY: 1 Month | Refills:

Siliq ® ☐ **210 mg/1.5 mL Prefilled Syringe (2 pack)** ☐ Starter Dose not needed — ☐ **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:

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. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

DERMATOLOGY REFERRAL FORM (Sim - Z)

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: ☐ L20, L20.8, L20.9 Atopic Dermatitis ☐ 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 ☐ Other: _____
- 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.

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

Simponi® ☐ **Aria 50 mg / 4 mL** Patient Weight (kg): _____ ☐ Starter Dose not needed ☐ **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** ☐ **50 mg / 0.5 mL Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
☐ 50 mg SQ every month — QTY: 1 Month | Refills:
☐ Other: _____ — QTY: | Refills:

Skyrizi® ☐ **150 mg / mL Pen Autoinjector** ☐ **150 mg / ml Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
☐ *Starter Dose:* 150 mg SQ at Week 0 and 4 ☐ Starter Dose not needed — QTY: 1 | Refills: 1
☐ *Maintenance Dose:* 150 mg SQ every 12 weeks — QTY: 1 | Refills:

Sotyku® ☐ 6 mg 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 45 mg | Refills: 1
☐ ≤ *100 kg Maintenance Dose:* 45 mg SQ every 12 weeks ☐ Other: _____ — QTY: 1 x 45 mg | 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 90 mg | Refills: 1
☐ > *100 kg Maintenance Dose:* 90 mg SQ every 12 weeks ☐ Other: _____ — QTY: 1 x 90 mg | Refills:

Taltz® ☐ **80 mg / mL Autoinjector** ☐ **80 mg / mL Prefilled Syringe** **Pen will be dispensed if no preference is indicated* ☐ Starter Dose not needed
☐ *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:
☐ *Starter 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® ☐ **100 mg / mL Pen Autoinjector** ☐ **100 mg / ml Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
☐ *Starter Dose:* 100 mg SQ at Week 0, 4, and every 8 weeks thereafter ☐ Starter Dose not needed — QTY: 1 | Refills: 0
☐ *Maintenance Dose:* 100 mg SQ every 8 weeks (starting at Week 4) — QTY: 1 | Refills:

Xeljanz® ☐ **5 mg Tablet** ☐ **10 mg Tablet:** 1 tablet PO twice daily — QTY: 1 Month | Refills:
☐ **11 mg ER Tablet:** 1 tablet PO daily — QTY: 1 Month | Refills:

Xolair® ☐ **150 mg Prefilled Syringe** ☐ **150 mg Vial**
☐ 150 mg SQ every 4 weeks ☐ 300 mg 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. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.