

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: DN	I □ F □ Oth	er:	V	Veight:	□lb	s. ⊡kg.
SSN:	Phone:	Allergies:	I				•		
Address:		Ŭ	City:		State:	7	Zip:		
Emergency Contact:		Phone:	2		Additional I				
PRESCRIBER INFORMATIO	N								
Prescriber:		NPI:		DEA:	5	State Lic:			
Supervising Physician:			Practice Name:						
Address:			City:		State:	7	Zip:		
Phone:	Fax:		Key Office Cont	act.	olulo.		Phone:		
	I / MEDICAL ASSESSMENT					1	nono.		_
	L20.8, L20.9 Atopic Dermatitis L28.1	Prurigo podularis			0.2.140.3.140.4	140.8.14	0.54 Peoriatic arth	hritis □1/	10 50
	caria L73.2 Hidradenitis Suppurativa [10.33
	□ Face □ Scalp □ Groin □ Nails □								
	BSA) □ Moderate (3-10% BSA) □ Sever		BSA), BSA	%					
	idition, please indicate which drugs have b								
Date range of previous therapy									
	y? □ Yes □ No Type / medication(s):								
	pove medication(s) before starting the new		s 🗆 No, if yes, how	v long should	patient wait before	starting th	e new medication	?	
 Has patient received a PPD ((tuberculosis) Skin Test? □ Yes □ No Re nd periodically during therapy, patient shou	sults:		and tootod for	latant infaction				
-		id be evaluated for		and tested for	latent mection.	_	_		_
INSURANCE INFORMATIO			·						
	back of patient's insurance card (me	edical and presc	ription)	_		_			_
COPAY CARD ENROLLME									
Please check if enrolling						_			_
PRESCRIPTION INFORMAT									
Adbry [®] 150 mg Prefilled						OTV. #		Defiles	0
	r Dose: 600 mg SQ on Day 1 nance Dose: 300 mg SQ every 4 weeks				ose not needed		4 Syringes / 14 DS 2 Syringes / 28 DS		0
	nance Dose: 300 mg SQ every other week						4 Syringes/28 DS		
Adbry [®] 🛛 300 mg Pen									
□ Starte	r Dose: 600 mg SQ on Day 1			Starter Do	ose not needed		#2 Pens/14 DS	Refills:	0
After 16 wks of treatment Mainten	nance Dose: 300 mg SQ every 4 weeks nance Dose: 300 mg SQ every other week						#1 Pens/28 DS #2 Pens/28 DS	Refills: Refills:	
	Syringe (Pediatric: 12 years and older)					Q11	#2 F elis/20 D3		
	r Dose: 300 mg SQ on Day 1			Starter Do	ose not needed	QTY: #2	2 Syringes / 14 DS	Refills:	0
☐ Mainter	nance Dose: 150 mg SQ every other week						2 Syringes/28 DS		
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 week	S			QTY:	2	Refills:	4
0.0	two 160 mg injections) SQ every 8 weeks					QTY:	2	Refills:	
Cibinqo [®] 🗆 50 mg lablet	□ 100 mg Tablet □ 200 mg Tablet daily □ Other:					QTY:	1 Month	Refills:	
Cimzia [®] 200 mg Vial						Q11			
□ 400 mg/mL SQ ev									
	eks 0, 2, 4, then 200 mg every other week	thereafter (patient :	≤ 90 kg)			QTY:	1 Month	Refills:	
Cosentyx [®] 150 mg/mL Senso	oready® Pen 🛛 150 mg/mL Prefilled Syrin	ge 🗆 300 mg UnoF	Ready Pen						
*Sensoready® Pen will b	e dispensed if no preference indicated		•			071			0
☐ Starter Dose: 300 mg SQ ☐ Maintenance Dose: 300 mg SQ	initially (Weeks 0, 1, 2, 3 and 4) then 300 mg s	SQ every 4 weeks the	ereafter (Week 4)	Starter Do	ose not needed	QTY: QTY:	5 Weeks 1 Month	Refills: Refills:	0
☐ Other:	every + weeks					QTY:	1 Month	Refills:	
Dupixent [®] 200 mg Pen Auto	injector 🛛 200 mg Prefilled Syringe 🗌	300 mg Pen Auto	oinjector 🗆 300 m	g Prefilled Sy	/ringe				
(Dupilumab) *Pen will be dispensed it	f no preference indicated for adult dosing. Prefilled Syrin	ge may be used in ages ≥	6 months. Prefilled Pen	is only for use in a	ges ≥ 2 years.				
	j. 600 mg SQ on Day 1, then 300 mg SQ e j. 300 mg SQ every 2 Weeks	very 2 weeks startir	ng on Day 15	□ Starter Do	ose not needed	QTY: QTY:	QS for Starter 1 Month	Refills:	0
	< 6 yrs: Initial loading dose not necessary ixent 200 mg SQ every 4 weeks			weeks		QTY: <u>1</u> E	Box: 2 Pens/Syringes	a Refills:	
Children & Adolescents: ≥ 6			· ·				-		
□ 15 to < 30 kg: Initial:		wo 300 mg injectior	is)				Box: 2 Pens/Syringes		0
□ 15 to < 30 kg: Mainte □ 30 to < 60 kg: Initial:	enance: 300 mg SQ every 4 weeks 400 mg SQ once (administered as t	wa 200 ma injection	(e)				Box: 2 Pens/Syringes Box: 2 Pens/Syringes		0
	enance: 200 mg SQ every other week					QTY:1E	Box: 2 Pens/Syringes	3 Refills:	
$\Box \ge 60 \text{ kg}$: Initial:	600 mg SQ once (administered as t	wo 300 mg injectior	is)			QTY: <u>1</u> E	Box: 2 Pens / Syringes	Refills:	0
$\Box \ge 60 \text{ kg}$: Mainte	enance: 300 mg SQ every other week					QTY: <u>1</u> E	Box: 2 Pens/Syringes	Refills:	
1									

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 (E - K)

PATIENT INFORMATION								
Patient Name:	DOB:	Sex: 🗆 M	□F□Oth	er:		Weight:	□ lbs	s. □kg.
SSN: Phone:	Allergies:						·	
Address:		City:		State:		Zip:		
Emergency Contact:	Phone:	,						
PRESCRIBER INFORMATION								
Prescriber:	NPI:		DEA:		State Lic:			
Supervising Physician:	111.	Practice Name:						
				Ctoto		7in:		
Address:		City:	1.	State:		Zip:		
Phone: Fax:		Key Office Cont	act:			Phone:	_	_
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT								
Primary Diagnosis: L20, L20.8, L20.9 Atopic Dermatitis L28.1						40.54 Psoriatic art	hritis 🗆 L4	0.59
L50.1 Chronic Idiopathic Urticaria L73.2 Hidradenitis Suppurativa								
Location: □ Hands □ Feet □ Face □ Scalp □ Groin □ Nails □								
Severity: □ Mild (up to 3% BSA) □ Moderate (3-10% BSA) □ Sever								
If treated previously for this condition, please indicate which drugs have b	een 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		□ No, if yes, how	long should p	patient wait befor	e starting t	he new medication	?	
 Has patient received a PPD (tuberculosis) Skin Test?	Sults:	ativa tubaraulasia d	and tootod for	latant infection				
	id be evaluated for a		and tested for	latent mection.	_		_	_
INSURANCE INFORMATION								
$\hfill\square$ Please attach front and back of patient's insurance card (methods)	edical and prescr	iption)						
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 Do	se not needed	QTY:	QS 28 DS	Refills:	0
☐ Maintenance Dose: 250 mg (1 injection) SQ every 2 weeks until Week 16	or later				QTY:		Refills:	
\Box Optional: 250 mg (1 injection) SQ every 4 weeks						QS 28 DS	Refills:	
Enbrel [®] 50 mg/mL SureClick (Autoinjector) 50 mg Prefilled Syrin		rtridge *SureClick wil				oll in Enliven® Pro	-	
□ Starter Dose: 50 mg SQ twice weekly (72 - 96 hours apart) for 3 mo	nths		□ Starter Do	se not needed	QTY:		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 Via	*Prefilled Syringe will be	e dispensed if no prefere	nce indicated					
□ 25 mg SQ twice weekly (72 - 96 hours apart) □ Other:					OTX.	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 4	0 mg/0.4 mL Prefil	led Syringe NDC	0074-0243-0	2	□ Enr	oll in Humira Com	nlete Prog	ram
*Pen Starter Kit will be dispensed if no preference indicated	-							- uni
□ Starter Dose □ One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8	, one 40 mg SQ inj. I	Day 22 _(OR)	2 (OR) Starter Do	ose not needed	QTY:	3 Pens	Refills:	0
for Psoriasis:	, one 40 mg SQ inj. I	Day 22			QTY:_	4 Syringes	Refills:	0
Humira [®] CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 CF 40 mg/	0.4 ml Svringe NC	0.0074-0243-02						
*Pen will be dispensed if no preference indicated	0.4 me byringe ne	0.001+02+0-02						
☐ Maintenance Dose for Psoriasis: 40 mg SQ once every other week					QTY:_	1 Month	Refills:	
			ND0 0074	0.40.00				
Humira Starter Pkg CF 80 mg/0.8 mL Pen NDC: 0074-0124-03 'Pen will be dispensed if no preference indicated	□ CF 40 mg/0.4 mL	Prefilled Syringe	NDC: 0074-0	1243-02				
□ Starter Dose for □ Inj. 160 mg SQ Day 1, then 80 mg SQ Da	v 15 (OR)		Starter Do	se not needed	QTY:	1 Month	Refills:	0
Hidradenitis Suppurativa: □ Inj. 80 mg SQ Day 1, and 80 mg SQ Day		av 15			QTY:	1 Month	Refills:	0
	-				~···_		1.101.001	
Humira [®] CF 40 mg/0.4 mL Pen <i>NDC</i> : 0074-0554-02 CF 40 mg/	0.4 mL Syringe ND	C: 0074-0243-02						
*Pen will be dispensed if no preference indicated Maintenance Dose for Hidradenitis Suppurativa: 40 mg SQ Day 29 and	over week there offe	-			QTY:	1 Month	Defile	
	every week increate	1			QTT:_	1 Month	Refills:	
					QIT		Rennis.	
Ilumya [®] D 100 mg/mL Prefilled Syringes								
□ Starter Dose: 100 mg SQ on Week 0 and Week 4			Starter Do	se 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:	
	and the second second							
Kevzara [®] 200 mg/1.14 mL Pen Autoinjector 200 mg/1.14 mL P	refilied Syringe *Pe	ns will be dispensed if no	preference is ind	icated	OTV.	1 Day (2)	Defile	
(Sarilumab)					QTY:_	1 Box (2)	Refills:	
Dressriberte Simotures						Deter		
Prescriber's Signature:	houthe to all a little in the			spense as Written		Date:		4
Prescriber certifies that this referral form contains an original signature and is signed official state prescription blank. In the event requested agent is not available through					vnere requir	eo by law, send electr	onic prescrip	mon or on
IMPORTANT NOTICE: This message may contain privileged and confidential information and is in		•	-		disseminate d	listribute or copy this for	Please notify	the sender
immediately if you have received this document by mistake, then destroy this document. Please of	lirect all verification or notifi	cation to AcariaHealth or	any of its subsidi	aries using the contact	information p	rovided on this covershe	et.	



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 (L - Sil)

Patient Name: DOB: Sox: TH FFTOPher: Weight: Thes. Link Address: DOY: State: Zp: Emergency Contact: Phone: JAddress: Zp: Emergency Contact: Phone: DAddress: Ld: Contact: Phone: DAddress: Ld: Contact: Phone: DAddress: Ld: Contact: DA	PATIENT INFORMATION					
SN. Phone: Allergies: Address: Dity: State: Zp: Preservice/Provider. NP: DEA State: Zp: Preservice/Provider. NP: DEA State: Zp: Phone: Chr: State: Prone:		DOB:	Sex: 🗆 M 🗆 F 🗆	Other:	Weight:	□lbs. □kg.
Energiency Contact: Phone: Indititional Information Attached Presschilter IDEA: State Lie: Supervising Physician: Pract: Pract: State Lie: Address: Dirk: State Lie: Zip: Phone: Dirk: State: Zip: Phone: Dirk: State: Zip: Phone: Dirk: State: Zip: Phone: Dirk: State: Zip: Usation: Phone: State: Zip: Usation: Phone: State: Zip: Usation: State: Zip: Zip: Phone: State: Zip: Zip: Phone: State: Zip: Zip: Phone: State: Zip: Zip: Phone: State: Zip: <	SSN: Phone:	Allergies:				
Emergency Contact: Phone: Image: Contact: Phone: Contact: Phone: Contact: Phone: State Lic: Prescriber Dr. NOSSIN INFORMATION INED/CALLASESSESURET Dr. Nossi: Image: Contact: Phone:	Address:		City:	State:	Zip:	
Prescriber IDP: IDEA: State Lic: Supervising Physician: IDp: Fraction Name: Zp: Address: IDp: State: Zp: Phone: IDA: State: Zp: Phone: Phone: IDA: State: Zp: Phone: IDA: State: Text: Note: State: Phone: IDA: State: Text: Note: State: Zp: IDA: State: Text: Note: Note: Note: Note: IDA: State: Text: Note: No	Emergency Contact:	Phone:				
Supervision: Practice Name: Phone: [Fax: [Address: [Zp:: Phone: [Fax: [Key Office Contact: [Phone: DARNOSIS: [C28,1208,1228,4228,435555KIENT [Phone: [Phone: DIVIS: [Contact: [Phone: [Phone: [Phone: DIVIS: [Contact: [Phone: [Phone: [Phone: DIVIS: [Contact: [Phone: [Phone: [Phone: DIVIS: [Phone:	PRESCRIBER INFORMATION					
Supervision: Practice Name: Phone: [Fax: [Address: [Zp:: Phone: [Fax: [Key Office Contact: [Phone: DARNOSIS: [C28,1208,1228,4228,435555KIENT [Phone: [Phone: DIVIS: [Contact: [Phone: [Phone: [Phone: DIVIS: [Contact: [Phone: [Phone: [Phone: DIVIS: [Contact: [Phone: [Phone: [Phone: DIVIS: [Phone:	Prescriber:	NPI:	DEA	٨:	State Lic:	
Address: Div: State: Zp: Phone: Fac: Key Office Contact: Phone: DIAMOSISINE/REMIATION MEDICAL ASSESSMENT: Phone: Phone: Diamosities: Diamosities: Diamosities: Diamosities: Phone: Diamosities: Diamosities: Diamosities: Diamosities: Diamosities: Phone: Location: Head previous: Salapit Control: Diamosities: Notified and the phone: Notified and the phone: Location: Head previous: Salapit Control: Diamosities: Notified and the phone: Notified and the phone: Location: Head previous: Diamosities: Notified and the phone: Notified andd	Supervising Physician:					
Phone: Fac: Key Office Contact: Phone: DIARNOSIS INFORMATION MEDIAL ASSESSMENT Primary Diagnosis: 12.0.0.3, L00.4, L00.8, L40.54 Pscinitic arthritis 12.0.3, Circle Contact: Phone: Diagnosis: 12.0.0.3, L00.4, L20.8, L20.9, AL20.4, ASSESSMENT Phone: Phone: Phone: Diagnosis: 12.0.0.3, L20.9, L20.9, L20.9, L20.9, L20.9, L20.9, Experience prime in the integet of t				State:	Zip:	
DIAMONOSISI INFORMATION MEDICAL ASSESSMENT Primary Diagnosis: 120.00.10.0000 August Demained TL28.1 Provide nodulatis: 124.00.0 Provide Size 124.00.0.0.00000000000000000000000000000			,			
Primary Diagnosts: L2.02.8, L20.8, L20.8, L20.5, L20.8, L20.5, L20.8, L20.5, Provides carthrifis L24.0.9 Pointsis: L2	DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT		, ,			
□B01 Otronic logastic Uticatal □L722 Hindradenilis Suppurates □ Other		1 Prurigo nodularis	□L40.0 Psoriasis □L40.1	: L40.2: L40.3. L40.4	4. L40.8. L40.54 Psoriatic	arthritis 🗆 L40.59
Location Hands Feet Face Fac	L50.1 Chronic Idiopathic Urticaria L73.2 Hidradenitis Suppurativa	□ Other:		, . , , .	,,	
If treaduperiously for this condition, please indicate which drugs have been tried and failed:	■ Location: □ Hands □ Feet □ Face □ Scalp □ Groin □ Nails □] Other:				
Deterange of previous therapy:						
		been tried and failed:				
	 Is patient currently on therapy? Uses Uno Type / medication(s): Will patient step taking the above medication(c) before starting the pair 	w modication? _ Vac	□ No if yos how long sho	uld nationt wait hofor	ro starting the new medical	tion?
Prior to Initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection. INSURANCE INFORMATION COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presses attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Adult Patients Weighing 90 to gor more is an initial dose of dorn (miai dose of dorn (miai dose of log mg (norm) of a mg indexins). Informed by 60 mg patient set of the set of the set of the set of the pression of the medical and prescription (C444) Adult Patients Weighing 90 to gor more is an initial dose of dorn (L444) Adult Patients Weighing 90 to gor more is an initial dose of dorn (L444) Adult Patients Weighing 90 to gor more is an initial dose of dorn (L444) Adult Patients Weighing 90 to gor more is an initial dose of dorn (L444) Adult Patients Weighing 90 to gor more is an initial dose of dorn (L444) Adult Patients Weighing 90 to gor more is an initial dose of log mg (Na44 & Na44) Defet Biol Biol Card (L444) Adult Patients Weighing 90 to gor more is an initial dose of log mg (Na44 & Na44) Defet Biol Biol Card (L444) Adult Patients Weighing 90 to gor more is an initial do				ulu patierit wait beroi	re starting the new medica	uon?
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 PRESCRIPTION INFORMATION Adult Patients Weighing test than 90 kg is an initial does of 60 mg (wo 30 mg injections), followed by 30 mg given every 4 weeks (C4W) Adult Patients Weighing test than 90 kg is than 90 kg is than 90 kg is an initial does of 60 mg (wo 30 mg injections), followed by 30 mg given every 4 weeks (C4W) Adult Patients Weighing test than 90 kg is in one of a wakes (C4W) Adult Patients Weighing 50 kg or more: in final does Off (wo 30 mg indictors), followed by 60 mg given every 4 weeks Odomzo ⁴ © 00 mg Capsule PO once Daily Otexta* Tablets Plaque Paoriasis - moderate to severe: Net Initiation Back: 10 mg in moming 2 0 mg in evening; DAY 3: 10 mg in moming 2 0 mg in evening; DAY 3: 10 mg in weed daily; OTY:	Prior to initiating treatment and periodically during therapy, patient sho	ould be evaluated for a	ctive tuberculosis and tested	d for latent infection.		
CPAsse attach front and back of patient's insurance card (medical and prescription) COPAY CARD ENROLLMENT Presse check if enrolling in copay card Copay ID: PRESSCIPTION INFORMATION Nemluvio* 30 mg Pen-The recommended subcateneous dosage of NEMLUVIO for aduit patients weighing less than 90 kg is an initial dose of 60 mg (Nov 30 mg injections). followed by 30 mg given every 4 weeks (C4W) Aduit Patients Weighing 10 kg or more: Inject 30 mg SQ every 4 weeks Nemluvio* 60 mg Pen-The recommended subcataneous dosage of NEMLUVIO for aduit patients weighing 90 kg or more is an initial dose of 60 mg (Nov 30 mg injections). Joilweed by 60 mg on ever 4 weeks (C4W) OTY: <u>#2 Pens/28 DS</u> Refilis: Nemluvio* 60 mg Pen-The recommended subcataneous dosage of NEMLUVIO for aduit patients weighing 90 kg or more is an initial dose of 00 mg (Nov 30 mg injections). Silveed by 60 mg one or every 4 weeks OTY: <u>#2 Pens/28 DS</u> Refilis: Odemzo* 200 mg Capsule PO Once Daily OTY: <u>#2 Pens/28 DS</u> Refilis: OTY: <u>#1 Pens/28 DS</u> Refilis: Odemzo* 200 mg Capsule PO Once Daily OTY: <u>#2 Pens/28 DS</u> Refilis: OTY: <u>#2 Pens/28 DS</u> Refilis: Odemzo* 200 mg Capsule PO Once Daily OTY: <u>#1 Pens/28 DS</u> Refilis: OTY: <u>#2 Pens/28 DS</u> Refilis: Otexis* Tablets Planes 20 mg in morning 3 0 mg in morning 3 20 mg in evening; DAY 6 & thereafter: 30 mg twice daily; Otexis* 20 mg Tablet: Tabl						
COPAX CARD ENROLLMENT Copay card Copay 1D: PRESCRIPTION INFORMATION PRESCRIPTION INFORMATION Nemlwrlo* □ 30 mg Pen - The recommended subculneous dosage of NEMLUVIO for adult patients weighing less than 90 kg is an initial dose of 60 mg (No 30 mg injections), followed by 30 mg given every 4 weeks (C4W) OTY: #2 Pens/28 DS. Refilis: Nemlwrlo* □ 60 mg Pen - The recommended subculneous dosage of NEMLUVIO for adult patients weighing 90 kg or more: is an initial dose of 60 mg (No 30 mg injections), followed by 50 mg given every 4 weeks (C4W) OTY: #2 Pens/28 DS. Refilis: Nemlwrlo* □ 60 mg Pen - The recommended subculneous dosage of NEMLUVIO for adult patients weighing 90 kg or more: inject 60 mg S0 every 4 weeks OTY: #2 Pens/28 DS. Refilis: Odomzo* □ 200 mg Capsule PO Once Daily Inject 60 mg S0 every 4 weeks OTY: #2 Pens/28 DS. Refilis:: Otecta* Tablets: Paque Peniasis - moderate to severe; Note: Initial dose Itiration is intended to reduce GI symptoms -Adults: - Adults: Tirration DAY 1: 10 mg in moming & 20 mg in evening; DAY 3: 10 mg in moming & 20 mg in weeking; DAY 4: 20 mg in Meming & 20 mg in meening; DAY 4: 8 therafter: 0al 20 mg twice daily; Otexta* 20 bg Treatment Initiation Pack: DAY 1: Oral: 10 mg once daily in the moming; DAY 2: Oral: 10 mg twice daily; OTY: _60 TABS (30 mg) in Refilis:: OTY: Day Testiment Initiation Pack: DAY 1: Oral: 10 mg once daily in the moming; DAY 4: 8 therafter: Oral: 20 mg twice daily; Dota's 20 bg Treattment I		nedical and prescr	iption)			
□ Please check if enrolling in copay card Copay ID: PRESCRIPTION INFORMATION Nemluvice* 0 mg (two 30 mg picetions), followed by 30 mg given every 4 weeks (C4W) Adult Patients Weighing less than 90 kg: Inject 30 mg SQ every 4 weeks (C4W) Nemluvice* 60 mg (two 30 mg picchons), followed by 30 mg given every 4 weeks (C4W) Adult Patients Weighing less than 90 kg: Inject 30 mg SQ every 4 weeks (C4W) Adult Patients Weighing 90 kg or more: Inject 80 mg SQ every 4 weeks (C4W) Adult Patients Weighing 90 kg or more: Inject 80 mg SQ every 4 weeks Odorxo* 220 mg Capsule PO Once Daily OTY: #2 Pens/28 DS Otexta* Thateion DAY 1: 0 mg in morning & 20 mg in evening: DAY 3: 20 mg in morning & 20 mg in evening: DAY 3: 20 mg in morning & 20 mg in evening: DAY 3: Coal: 10 mg in morning & 20 mg on evering: DAY 3: 20 mg in morning & 20 mg on cells; OTY: #1 Month Refilis: Ofther:						
PRESCRIPTION INFORMATION Nemluvio® □ 30 mg Pen - The incommended subcutaneous docage by 30 mg given every 4 weeks (Q4W) Adult Patients Weighing less than 90 kg :: Inject 80 mg S2 once for initial dose D mg (Iwo 30 mg injections), Ioliowed by 60 mg S2 every 4 weeks Oftmation Adult Patients Weighing less than 90 kg:: Inject 80 mg S2 every 4 weeks Oftmation Adult Patients Weighing 90 kg or more: Inject 80 mg S2 every 4 weeks Odmaco® □ 200 mg Capsule P0 Once Daily Otexale * Tablets Plaque Psoriasis - moderate to severe; Note: Initial dose if/ration is intended to reduce GI symptoms - Adult = Tablets Plaque Psoriasis - moderate to severe; Note: Initial dose if/ration is intended to reduce GI symptoms - Adult = Children & Adolescents: ≥ 6 years weighing 20 to < 50 kg;						
Nemluvio [®] □ 30 mg Pen - The recommended subcutaneous dosage of NEMLUVIO for adult patients weighing less than 30 kg is an initial dose of 60 mg (two 30 mg injections), followed by 30 mg given every 4 weeks (Q4W) QTY: #2 Pens/28 DS Refilis: 0 Adult Patients Weighing less than 30 kg is an initial dose 0 DTY: #1 Pens/28 DS Refilis: 0 Memluvio [®] □ 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 injectors), followed by 60 mg SQ once for initial dose QTY: #2 Pens/28 DS Refilis: 0 Memluvio [®] □ 200 mg Capsule PO Once Daily Otre: an initial dose infraid dose iffration is intended to reduce GI symptoms QTY: #2 Pens/28 DS Refilis: 0 Odomzo [®] □ 200 mg Capsule PO Once Daily Otte: Initial dose iffration is intended to reduce GI symptoms QTY: all Capsule Poince daily QTY: #1 Pens/28 DS Refilis: 0 Ottexta [®] 28 Day freatment Initiation Pack: DAY 3: 00 mg in evening: DAY 3: 10 mg in moming & 20 mg in evening: DAY 3: 00 mg in evening: DAY 2: 0rai: 10 mg twice daily; QTY: #1 Refilis: 0 QTY: #1 Refilis: 0 Ottexta [®] 28 Day freatment Initiation Pack: DAY 1: Orai: 10 mg once daily in the moming: DAY 2: Orai: 10 mg twice daily; QTY: #1 Refilis: 0 QTY: #1 Refilis: 0 Ottexta [®] 28 Day freatment Initiation Pack: DAY 1: Orai: 10 mg once daily in the moming: DAY 2: Orai: 10 mg twice daily; QTY: #1 Refilis: 0 QTY: #1 Refilis: 0 Ottexta [®] 28 Day freatment Initiation						
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Adult Patients Weighing less than 90 kg: □ inject 60 mg SQ order for initial dose CTY: #2 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 0 mg (hor 30 mg injections). followed by 60 mg given every 4 weeks CTY: #2 Pens/28 DS Refills: Adult Patients Weighing 90 kg or more: □ inject 60 mg SQ every 4 weeks CTY: #2 Pens/28 DS Refills: Odomzo* □ 200 mg Capsule PO Once Daily CTY: #2 Pens/28 DS Refills: Otexta* Tables Plaque Psoriasis - moderate to severe; Note: Initial dose litration is intended to reduce GI symptoms - Adults: Inject 60 mg NA *2: 00 mg in morning; DAY 2: 10 mg in morning; DAY 2: 0 mg in morning; DAY 3: 0 mg in evening; Dose: DAY 4: 20 mg in morning; DAY 2: 10 mg in morning; AV 3: 20 mg in evening; DAY 3: 20 mg in evening; CTY: #2 Pens/28 DS Refills: Other: - Children & Adolescents: ≥ 6 years weighing 20 to < 50 kg:						
Nemluvio* 60 mg Pen - The recommended subcutaneous dosage of NEML UVIO for adult patients weighing 90 kg or more is an initial dose of 60 mg (two 30 mg injectoros), followed by 60 mg given every 4 weeks (Q4W) Adult Patients Weighing 90 kg or more: Inject 60 mg SQ ore for initial dose Odomzo* 200 mg Capsule PO Once Daily Oterace* Thereton DAY 1: 10 mg in moming 2.0 DAY 2: 10 mg in moming & 10 mg in evening: Dose: DAY 4: 20 mg in moming & 20 mg in evening: Dose: DAY 4: 20 mg in moming & 20 mg or in evening: Dose: DAY 4: 20 mg in moming & 20 mg or in evening: Dotter: — Children & Adolescents: > 6 years weighing 20 to < 50 kg:					QTY: #2 Pens/28 D	S Refills: 0
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Adult Patients Weighing 90 kg or more: Inject 60 mg SQ once for initial dose OTY: #2 Pens/28 DS Refills: Odomzo* 200 mg Capsule PO Once Daily OTY: #2 Pens/28 DS Refills: OTY: #2 Pens/28 DS Refills: O Obtacle* Tablets Plaque Psoriasis - moderate to severe; Note: Initial dose titration is intended to reduce GI symptoms OTY: #30 CAPS Refills: OTY: #30 CAPS Refills: OTY: #0 CAPS Refills: OTY: #30 CAPS Refills: OTY: #0 CAPS Refills: OTY: #30 CAPS R	Nemluvio [®] 60 mg Pen - The recommended subcutaneous dosage of NEI	MLUVIO for adult patien	ts weighing 90 kg or more is a	an initial dose of		
Inject 60 mg SQ every 4 weeks QTY: #2 Pens/28 DS Refills: Odomzo® □ 200 mg Capsule PO Once Daily QTY: 30 CAPS Refills: Otecla® Tablets Plaque Psoriasis - moderate to severe; Note: Initial dose titration is intended to reduce GI symptoms - Adults: QTY:			Q4W)			
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 QTY: 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 evening; DAY 5: 20 mg in morning & 30 mg in evening; DAY 5: 0 mg in morning & 30 mg in evening; DAY 6 & thereafter: 30 mg twice daily QTY: 1 Month Refills: 0 Other: Children & Adolescents: ≥ 6 years weighing 20 to < 50 kg:						
Otezla* Tablets Plaque Psoriasis - moderate to severe; Note: Initial dose titration is intended to reduce GI symptoms Aduits: Trataion 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 3: 10 mg in evening; DAY 4: 20 mg in morning & 20 mg in the evening; DAY 3: 10 mg in wenning; DAY 4: 20 mg in the fills: 0TY:	☐ Inject 60 mg SQ 0	every 4 weeks			QTY: <u>#2 Pens/28 D</u>	S Refills:
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Dose: DAY 4: 20 mg in moming & 20 mg in evening; DAY 5: 20 mg in moming & 30 mg in evening; DAY 6 & thereafter: 30 mg twice daily Maintenance Dose: 30 mg twice daily QTY: 60 TABS (30 mg) Refills: Otezla* 28 Day Treatment Initiation Pack: DAY 1: Oral: 10 mg once daily in the morning; DAY 2: Oral: 10 mg twice daily QTY: # 1 Refills: Otezla* 28 Day Treatment Initiation Pack: DAY 1: Oral: 10 mg once daily in the evening; DAY 2: Oral: 10 mg twice daily QTY: # 1 Refills: 0 Otezla* 28 Day Treatment Initiation Pack: DAY 1: Oral: 10 mg once daily in the evening; DAY 2: Oral: 10 mg twice daily QTY: # 1 Refills: 0 Otezla* 28 Day Treatment Initiation Pack: DAY 1: Oral: 10 mg once daily in the morning; DAY 2: Oral: 10 mg twice daily; QTY: # 1 Refills: 0 DAY 3: Oral: 10 mg in the morning & 20 mg in the evening; DAY 4: Oral: 20 mg twice daily; DAY 6: Chass 30 mg Tablet: Take 30 mg Tablet: Refills: 0 DAY 5: Oral: 20 mg Vial Inflectra* 100 mg Powder Vial Renflexis* 100 mg Powder Vial Avsola* 100 mg Powder Vial Enroll in AccessOneSM Program Mb/b o's Office Infusion Home Infusion Supplies Required Starter Dose not neededd						
□ Maintenance Dose: 30 mg twice daily QTY: 60 TABS (30 mg) Refills: □ Children & Adolescents: ≥ 6 years weighing 20 to < 50 kg:					QTY: 1 Month	Refills: 0
□ Other:		g in morning & 30 mg in	evening; DAY 6 & thereafter	er: 30 mg twice daily		
- 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; QTY: #1 Refills: 0 □ Otezla® 20 mg Tablet: Take 20 mg in the evening; DAY 4 & therafter: Oral: 20 mg twice daily QTY:					QTY:	Refills:
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□ Otezla® 20 mg Tablet: Take 20 mg PO twice daily QTY: 60 TABS Refills: □ Children & Adolescents: ≥ 6 years weighing ≥ 50 kg: QTY: 60 TABS Refills: □ 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: 20 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 4: Oral: 20 mg twice daily QTY: # 1 Refills: 0 □ Otezla® 30 mg Tablet: Take 30 mg PO twice daily QTY: 60 TABS Refills: QTY: 60 TABS Refills: □ Remicade® 100 mg Vial Inflectra® 100 mg Powder Vial Renflexis® 100 mg Powder Vial Avsola® 100 mg Powder Vial Starter Dose not needed □ Enroll in AccessOneSM Program □ Starter Dose:				e daily;	QTY: #1	Refills: 0
- Children & Adolescents: ≥ 6 years weighing ≥ 50 kg: QTY: # 1 Refills: 0 QTY: @ 1		DAT 4 & therafter:	Oral: 20 mg twice daily			Pofille
□ 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:	•					
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DAY 5: Oral: 20 mg in the morning & 30 mg in the evening; DAY 6 & therafter: Oral: 30 mg twice daily Otezla® 30 mg Tablet: Take 30 mg PO twice daily Remicade® 100 mg Vial Inflectra® 100 mg Powder Vial Renflexis® 100 mg Powder Vial Avsola® 100 mg Powder Vial MD's Office Infusion Home Infusion Supplies Required Starter Dose not needed Image: The second secon	DAY 3: Oral: 10 mg in the morning & 20 mg in the evening:	DAY 4: Oral: 20 mg	y, DAT 2: Oral. 10 mg twic	e dally,	QIT. <u>#1</u>	Remis. U
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□ MD's Office Infusion □ Home Infusion Supplies Required □ Starter Dose: mg IV on Week 0, Week 2, Week 6, then □ Maintenance Dose: mg IV everyweeks Rinvoq® □ 15 mg Tablet □ 30 mg Tablet Take 1 tablet PO once daily Siliq ® □ 210 mg /1.5 mL Prefilled Syringe (2 pack) □ Starter Dose not needed □ TY: I Month Refills: □ Starter Dose for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose □ Starter Dose not needed □ TY: I Box (2 PFS) Refills: □ Prescriber's Signature: □ DAW (Dispense as Written) Date:	Remicade® 100 mg Vial Inflectra® 100 mg Powder Vial Renfle	xis®100 ma Powder \	/ial 🗆 Avsola®100 mg Po	wder Vial	Enroll in AccessO	neSM Program
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: 0 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 for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose Starter Dose not needed Enroll in REMS Program Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks (Starting at Week 2) QTY: 1 Box (2 PFS) Refills: 0 Prescriber's Signature: DAW (Dispense as Written) Date:			-			ncom riogram
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 □ Starter Dose not needed □ Starter Dose for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose □ Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks (Starting at Week 2) □ DAW (Dispense as Written) Date:					QTY: QS 3 Infusion	s Refills: 0
Siliq © 210 mg / 1.5 mL Prefilled Syringe (2 pack) □ Starter Dose for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose □ Starter Dose for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose □ Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks (Starting at Week 2) □ Enroll in REMS Program □ Prescriber's Signature: □ DAW (Dispense as Written) □ Date:	Maintenance Dose: mg IV every week	S			QTY: QS 1 Infusior	n Refills:
Siliq © 210 mg / 1.5 mL Prefilled Syringe (2 pack) □ Starter Dose for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose □ Starter Dose for Plaque Psoriasis: 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose □ Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks (Starting at Week 2) □ Enroll in REMS Program □ Prescriber's Signature: □ DAW (Dispense as Written) □ Date:	Rinvoq [®] 15 mg Tablet 30 mg Tablet Take 1 tablet PO once d	laily			QTY: 1 Month	Refills:
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: 0 Prescriber's Signature: DAW (Dispense as Written) Date:			□ Starte	r Dose not needed	Enroll in REMS Pro	ogram
Image: Maintenance Dose for Plaque Psoriasis: 210 mg SQ once every two weeks (Starting at Week 2) QTY: <u>1 Box (2 PFS)</u> Refills: Image: Prescriber's Signature: Image: DAW (Dispense as Written) Date:		2, followed by mainter				
Prescriber's Signature: DAW (Dispense as Written) Date:						
Prescriber's Signature: □ DAW (Dispense as Written) Date:						
Unacesticate that the retering form contains an eviding and is signed to the function and is signed to the function and is signed to the function of the funct	Prescriber's Signature:	ad by the transfer		V (Dispense as Writter	n) Date:	advania americati

official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy. IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.



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 (Sim - Z)

PATIENT INFORMATION					
Patient Name:	DOB:	Sex: □M □F □Oth	ner:	Weight:	□lbs. □kg.
SSN: Phone:	Allergies:				
Address:		City:	State:	Zip:	
Emergency Contact:	Phone:		□ Additional I	nformation Attached	
PRESCRIBER INFORMATION	. <u>.</u>				
Prescriber:	NPI:	DEA:	5	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					thritis 🗆 L40.59
L50.1 Chronic Idiopathic Urticaria L73.2 Hidradenitis Suppurativa					
Location: Hands Feet Face Scalp Groin Nails					
■ Severity: □ Mild (up to 3% BSA) □ Moderate (3-10% BSA) □ Sever					
If treated previously for this condition, please indicate which drugs have b	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?	No if ves how long should	natient wait before	starting the new medication	n?
 Has patient received a PPD (tuberculosis) Skin Test? □ Yes □ No Re 				otarting no now modelate	
Prior to initiating treatment and periodically during therapy, patient should be a second sec	uld be evaluated for a	active tuberculosis and tested for	r latent infection.		
INSURANCE INFORMATION					
□ Please attach front and back of patient's insurance card (m	edical and presc	ription)			
COPAY CARD ENROLLMENT	····	1 7			
□ Please check if enrolling in copay card Copay ID:					
PRESCRIPTION INFORMATION					
Simponi [®] Aria 50 mg/4 mL Patient Weight (kg):		Starter D	ose not needed	Enroll in SimponiOn	e® Program
□ Starter Dose: 2 mg/kg IV at Weeks 0 and 4				QTY: <u>1 Month</u>	Refills: 0
☐ Maintenance Dose: 2 mg / kg IV every 8 weeks				QTY: QS for 8 Weeks	
Simponi [®] SmartJect 50 mg/0.5 mL 50 mg/0.5 mL Prefilled Syr	inge *Dono will be dien	anod if no proforman in indicated			
□ 50 mg SQ every month	inge Pens will be dispe	nseu il no preletence is indicated		QTY: 1 Month	Refills:
□ Other:				QTY:	Refills:
Skyrizi ® 150 mg/mL Pen Autoinjector 150 mg/ml Prefilled Sy	ringo *Dene will be die	named if an amformum in indicated		- ····	1
Starter Dose: 150 mg SQ at Week 0 and 4	ringe "Pens will be dis		ose not needed	OTY· 1	Refills: 1
☐ Maintenance Dose: 150 mg SQ every 12 weeks				QTY: <u>1</u> QTY: <u>1</u>	Refills:
Sotyku [®] □ 6 mg PO once daily				QTY:	Refills:
					-
Stelara® Prefilled Syringe Vial MD's Office Infusion Home Infu			erence is not indicated	Enroll in Janssen Ca	
□ ≤ 100 kg Starter Dose: 45 mg SQ initially (Week 0), then 45 mg SQ □ ≤ 100 kg Maintenance Dose: 45 mg SQ every 12 weeks □ Other:	Q after 4 weeks of In	Itial dose (vveek 4)		QTY: <u>1 x 45 mg</u> QTY: <u>1 x 45 mg</u>	Refills: 1
$\square > 100 \text{ kg}$ Maintenance Dose: 45 mg SQ every 12 weeks \square Other	O after 4 weeks of in	itial dose (Week 4)		QTY: <u>1 x 90 mg</u>	Refills: 1
$\square > 100 \text{ kg}$ Maintenance Dose: 90 mg SQ every 12 weeks \square Other:				QTY: <u>1 x 90 mg</u>	Refills:
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Taltz® 80 mg / mL Autoinjector 80 mg / mL Prefilled Syringe □ Starter Dose for Plaque Psoriasis: 160 mg (two 80 mg inj.) at Week			ose not needed	QTY: 8	Refills: 0
☐ Maintenance Dose for Plaque Psoriasis: 80 mg every 4 weeks	o, then oo mg at we	56K 2, 4, 0, 0, 10, 12		QTY: <u>1</u>	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 Sy	ringe *Pens will be dis	pensed if no preference is indicated			
□ Starter Dose: 100 mg SQ at Week 0, 4, and every 8 weeks thereaft	-		ose 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:
				<u> </u>	
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:
				QTT. <u>20 Day Supply</u>	
Prescriber's Signature:			vispense as Written)	Date:	
Prescriber certifies that this referral form contains an original signature and is signed	d by the treating prescr				ronic prescription or on
official state prescription blank. In the event requested agent is not available through	h AcariaHealth, this pre	scription shall be forwarded to an elig	gible pharmacy.		
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