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

A-G 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).

Cibinqo® ☐50mg tablet ☐100mg tablet ☐200mg tablet
☐1 tablet po once daily ☐Other _____ QTY: 1 month Refills: ____

Cimzia® ☐ 400 mg/mL SQ every 2 weeks
☐ 400mg sq at weeks 0, 2, 4, then 200mg every other week thereafter (patient <=90kg)

Cosentyx® ☐150 mg/mL Sensoready® Pen ☐Prefilled Syringe 150 mg/mL ☐150 mg Vial of Lyophilized powder
*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 (1 syringe) SQ every 2 Weeks QTY: 1 month Refills: ____
Infants and Children ≥6 mo - <6 yrs: Initial loading dose not necessary in pediatric patients <6 yrs.
☐ 5 to <15 kg: Dupixent 200mg SQ every 4 weeks ☐15 to <30 kg: Dupixent 300 mg SQ every 4 weeks QTY: 1 box of 2 pen/syr Refills: ____
Children and Adolescents ≥6 years - ≤17 years:
☐ 15 to <30 kg: Initial: 600 mg SQ once (administered as two 300 mg injections), followed by maintenance dose of 300 mg every 4 weeks QTY: 1 box of 2 pen/syr Refills: 0
☐ 15 to <30 KG: maintenance: 300mg SQ every 4 weeks QTY: 1 box of 2 pen/syr Refills: ____
☐ 30 to <60 kg: Initial: 400 mg SQ once (administered as two 200 mg injections), followed by maintenance dose of 200 mg every other week QTY: 1 box of 2 pen/syr Refills: 0
☐ 30 to <60kg: maintenance: 200mg SQ every other week QTY: 1 box of 2 pen/syr Refills: ____
☐ ≥60 kg: Initial: 600 mg SQ once (administered as two 300 mg injections), followed by a maintenance dose of 300 mg every other week QTY: 1 box of 2 pen/syr Refills: 0
☐ ≥60kg: maintenance: 300mg SQ every other week QTY: 1 box of 2 pen/syr Refills: ____

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

☐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:

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.