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

H-R 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).

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

Dose	QTY	Refills
☐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)	3 pens	0
☐Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22	4 syringes	0
☐Starter Dose not needed.		

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

Dose	QTY	Refills
☐Maintenance Dose for Psoriasis: 40 mg SQ once every other week	1 month	_____

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

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

Humira® ☐CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 ☐CF 40 mg/0.4 mL Syringe NDC: 0074-0243-02

Dose	QTY	Refills
☐Maintenance Dose for hidradenitis suppurativa: 40 mg SQ Day 29 and every week thereafter	1 month	______
☐Other ____________________	_________	______

Ilumya® ☐100 mg/mL Prefilled syringes

Dose	QTY	Refills
☐ Starter Dose: 100 mg SQ on Week 0 and Week 4	1 month (1 PFS)	0
☐ Maintenance Dose: 100 mg SQ every 12 weeks (starting at week 4)	1 syringe	______

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

Dose	QTY	Refills
☐200 mg subcutaneously every 2 Weeks	1 box (2)	_____

Dose	QTY	Refills
Odomzo® ☐200 mg Capsule PO Once Daily	30 caps	______

Otezla® Tablets

Dose	QTY	Refills
☐Titration Dose: Day 1: 10 mg in morning; Day 2: 10 mg in morning and 10 mg in evening; Day 3: 10 mg in morning and 20 mg in evening; Day 4: 20 mg in morning and 20 mg in evening; Day 5: 20 mg in morning and 30 mg in evening; Day 6 and thereafter: 30 mg twice daily	1 month	0
☐Maintenance Dose: 30 mg twice daily	60 tabs (30mg)	_____
☐Other ____________________	______	_____

☐**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

Dose	QTY	Refills
☐Starter Dose: ________ mg IV on Week 0, Week 2, Week 6, then	QS 3 infusions	0
☐Maintenance Dose: _________ mg IV every ________Weeks	QS 1 infusions	_____

Dose	QTY	Refills
Rinvoq® ☐15mg tablet ☐30mg tablet 1 tablet po once daily	1 month	______

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.

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