RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
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QUESTIONS? Please Contact Us!
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Dermatology Prescription Referral Form

Send your Rx to: (optional)
Select Location

Date Medication Needed: _____ Ship To: (☐) Patient's Home (☐) Prescriber's Office (☐) Pick-Up (store location): _____ Injection training by pharmacy? ❑

1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (Prescription and Medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: (☐) Male (☐) Female Height: _____ Weight: _____ (☐) lbs. (☐) kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Diagnosis ❑ ICD-10 ❑ L40 (Plaque Psoriasis) ❑ L40 (Psoriasis) ❑ L40.5 (Psoriatic) ❑ L73.2 (Hidradenitis Supp.) ❑ L40.8 (other Psoriasis)
Diagnosis Date: _____ Affected Areas: ❑ Palms ❑ Soles ❑ Head ❑ Neck ❑ Groin/Genitals ❑ Other: _____
Moderate to severe **Atopic Dermatitis (AD)** that is in adequately controlled on current or prior topical therapy: (○) Yes (○) No
Indicate prior therapy: _____ BSA Level: ❑ >10% ❑ <10%

4) Prescription Information

MEDICATION	DOSE/STRENGTH		SIG	QTY.	REFILLS
❑ **Cimzia SubQ Kit®**	❑ 200mg ❑ 400mg		❑ Inject 400mg (2 subcutaneous injections of 200mg) initially and at weeks 0, 2 and 4. ❑ Inject 200mg every other week; 400mg every 4 weeks may be considered.		
❑ **Cosentyx Sensoready®**	❑ 150mg/ml		❑ Inject 300mg subcutaneously once weekly at weeks 0, 1, 2, 3, and 4.		
❑ **Dupixent®** (dupilumab)	❑ 300mg/2ml		❑ **Initial Dose:** 600mg SC on day 1 (x 2 injections) ❑ **Maintenance:** 300 mg SC every 2 weeks starting on day 15		
❑ **Enbrel®** (etanercept)	❑ 25mg/0.5ml ❑ 50mg/ml		❑ Inject 50mg subcutaneously twice weekly for 3 months. ❑ Inject 50mg subcutaneously once weekly.		
❑ **Enbrel Peds®**	❑ 25mg/0.5ml ❑ 50mg/ml	PFS Sureclick	❑ Inject 0.8mg/kg subcutaneously **(patient <63 kg)** *once weekly.* ❑ Inject 50mg subcutaneously **(patient >63 kg)** *once weekly.*		
❑ **Humira®** (adalimumab)	❑ 10/0.2ml ❑ 20/0.4ml ❑ 40/0.8ml	Pen Prefill Syr	❑ **Plaque psoriasis:** Inject 80mg subcutaneously as a single dose. **Inject** 40mg subcutaneously *every other week starting 1 week after the initial dose.* ❑ **Hidradenitis suppurativa (Humira only):** Inject 160mg subcutaneously *(on day 1)* followed by 80mg subcutaneously *2 weeks later (day 15).* Inject 40mg subcutaneously *(every week beginning on day 29).*		
❑ **Juvederm Volbella XC®**	❑ gel: 15mg/ml ❑ inj: 17.5mg/ml	PFS	❑ Inject Facial Wrinkle: 20ml/60kg/year.		
❑ **Orencia®** (abatacept)		PFS Clickject	❑ Infuse _____ mg at weeks 0, 2 and 4. Then every 4 weeks after. ❑ Inject 125mg subcutaneously once a week.		
❑ **Otezla®** (apremilast)	❑ 10mg ❑ 20mg ❑ 30mg	Tab Therapy Pack	❑ 10mg in the morning on day 1. Then 10mg/day on days 2 to 5 as follows: Day 2: 10mg twice daily; Day 3: 10mg in the morning and 20mg in the evening; Day 4: 20mg twice daily; Day 5: 20mg in the morning and 30mg in the evening. 30mg twice daily starting on day 6.		
❑ **Simponi®** (golimumab)	Autoinject PFS		❑ Inject 50mg subcutaneously once per month.		
❑ **Stelara®** (ustekinumab)	❑ 45mg/0.5ml ❑ 90 mg/ml	PFS	❑ Inject 45mg subcutaneously initially and 4 weeks later, and then 45mg every 12 weeks thereafter. Can be given with or without MTX. **Coexistent moderate to severe plaque psoriasis and weight more than 100 kg;** Inject 90mg subcutaneously initially and 4 weeks later. Then 90mg every 12 weeks thereafter. ❑ **Peds off label** - Plaque psoriasis *(off-label) > 12years.* **<60 kg** 0.75mg/kg subcutaneously *at 0 and 4 weeks, and then every 12 weeks thereafter.* **60 kg -100 kg** 45mg subcutaneously *at 0 and 4 weeks, and then every 12 weeks thereafter.* **>100 kg** 90mg subcutaneously *at 0 and 4 weeks, and then every 12 weeks thereafter.*		
❑ **Tremfya®** (guselkumab)	❑ 100mg/ml	PFS	❑ Inject 100mg subcutaneously at weeks 0, 4, and then every 8 weeks thereafter.		

5) Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature _____ **Date** _____

6) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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