# Dermatology Prescription Referral Form

# A-O

blue sky SPECIALTY PHARMACY

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## PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ SSN: _____ **(PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS)**

## PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

## PATIENT CLINICAL INFORMATION / HISTORY

Diagnosis: _____ ICD 10: _____ Weight:_____ Height: _____ Tb Test Results: _____

Drug Allergies:_____ BSA%:_____

Previous / Failed Medications:_____

_____ **(PLEASE FORWARD CHART NOTES AND RELEVANT LABS)**

## PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver medication to patient ☐ Deliver medication to MD

| MEDICATION | DOSAGE | SIG | QTY | REFILLS |
|---|---|---|---|---|
| ☐ CIMZIA | ☐ 200mg/mL Starter Kit<br>☐ 200mg/mL PFS<br>Weight:_____ | ☐ Induction Dose (if ≤90kg): Inject 400mg SC on week 0, at weeks 2 and week 4.<br>☐ Maintenance Dose: Inject _____ mg SC every other week | 3 | 0 |
| ☐ COSENTYX | ☐ 150mg/mL PFS<br>☐ 150mg/mL Sensoready | ☐ Induction Dose: Inject 300mg SC on weeks 0, 1, 2, 3, and 4.<br>☐ Maintenance Dose: Inject 300mg SC every 4 weeks | 10 | 0 |
| ☐ DUPIXENT | ☐ 300mg/2mL PFS<br>☐ 300mg/2mL Pen<br>☐ 200mg/1.14mL PFS | ☐ Induction Dose: Inject 600mg SC on day 1<br>☐ Maintenance Dose: Inject 300mg SC every 2 weeks thereafter<br>☐ Induction Dose: Inject 400mg SC on day 1<br>☐ Maintenance Dose: Inject 200mg SC every 2 weeks thereafter | 4 | 0 |
| ☐ ENBREL | ☐ 50mg Mini ☐ 50mg/mL PFS<br>☐ 50mg/mL SureClick | ☐ Induction Dose (Psoriasis): Inject 50mg SC twice weekly for 12 weeks<br>☐ Maintenance Dose: Inject 50mg SC once weekly | 8 | 2 |
| ☐ HUMIRA | ☐ Psoriasis Starter Kit<br>☐ 40mg/0.4mL PFS<br>☐ 40mg/0.4mL Pen | ☐ Induction Dose: Inject 80mg SC on day 1, then inject 40mg SC on day 8, and inject 40mg SC on day 22<br>☐ Maintenance Dose: Inject 40mg SC every 2 weeks<br>☐ Other:_____ | 3 | 0 |
| | ☐ HS Starter Kit<br>☐ 40mg/0.4mL PFS<br>☐ 40mg/0.4mL Pen<br>☐ 80mg/0.8mL PFS<br>☐ 80mg/0.8mL Pen | ☐ Induction Dose: Inject 160mg SC on day 1, then inject 80mg SC on day 15.<br>☐ Maintenance Dose: Inject 40mg SC once weekly<br>☐ Maintenance Dose: Inject 80mg SC every other week<br>☐ Other:_____ | 3 | 0 |
| ☐ OTEZLA | ☐ Starter Pack<br>☐ 30mg Tablet | ☐ Titration: Take 1 tablet by mouth at week 0 then increase as directed<br>☐ Take 30mg by mouth twice daily | 55 | 0 |

## PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I Authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process/appeals if necessary, in doing so, to release clinical information via phone/fax to appropriate third party payor.