

# DERMATOLOGY A-N

## Prescription Referral Form



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### PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Patient Preferred Language:  English  Spanish  \_\_\_\_\_

### PRESCRIBER INFORMATION

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Office's Preferred Method of Contact:  Phone  Fax  Portal  Email: \_\_\_\_\_  Other: \_\_\_\_\_

### PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis: \_\_\_\_\_ ICD 10: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Tb Test Results: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_ BSA%: \_\_\_\_\_ Previous / Failed Medications: \_\_\_\_\_

### PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver Medication to Patient  Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> ADBRY	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 300mg/2mL Autoinjector	<input type="checkbox"/> <u>Induction Dose:</u> Inject 600mg SC on Day 1 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 300mg SC every _____ weeks	4	0
<input type="checkbox"/> BIMZELX	<input type="checkbox"/> 160mg/mL PFS <input type="checkbox"/> 160mg/mL Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject 320mg SC on weeks 0, 4, 8, 12, and 16 <input type="checkbox"/> <u>Induction Dose:</u> Inject 320mg SC on weeks 0, 2, 4, 6, 8, 10, 12, 14 and 16 <input type="checkbox"/> <u>Maintenance Dose</u> (<120kg): Inject 320mg SC every 8 weeks <input type="checkbox"/> <u>Maintenance Dose</u> (>120kg): Inject 320mg SC every 4 weeks	10 18	0 0
<input type="checkbox"/> CIBINQO	<input type="checkbox"/> 50mg Tab <input type="checkbox"/> 100mg Tab <input type="checkbox"/> 200mg Tab	<input type="checkbox"/> Take _____mg by mouth once daily		
<input type="checkbox"/> CIMZIA Weight: _____	<input type="checkbox"/> 200mg/mL Starter Kit <input type="checkbox"/> 200mg/mL PFS	<input type="checkbox"/> <u>Induction Dose:</u> (if <90kg) Inject 400mg SC on week 0, week 2, and week 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject _____ mg SC every other week	3	0
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 300mg/mL PFS <input type="checkbox"/> 150mg/mL SensoReady <input type="checkbox"/> 300mg/mL UnoReady	<input type="checkbox"/> <u>Induction Dose:</u> Inject 300mg SC on weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 300mg SC every 4 weeks <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 300mg SC every 2 weeks	10	0
<input type="checkbox"/> DUPIXENT	<input type="checkbox"/> 300mg/2mL PFS <input type="checkbox"/> 300mg/2mL Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject 600mg SC on day 1 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 300mg SC every 2 weeks thereafter	4	0
<input type="checkbox"/> EBGLYSS	<input type="checkbox"/> 250mg/mL PFS <input type="checkbox"/> 250mg/mL Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject 500mg SC on week 0 and 2 then inject 250mg SC every 2 weeks until week 16 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 250mg SC every _____ weeks		
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg Mini <input type="checkbox"/> 50mg/mL SureClick	<input type="checkbox"/> <u>Induction Dose:</u> (Psoriasis) Inject 50mg SC twice weekly for 12 weeks <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 50mg SC once weekly	8	2
<input type="checkbox"/> HUMIRA	<input type="checkbox"/> Psoriasis Starter Kit Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> HS Starter Kit Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 80mg/0.8mL Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject 80mg SC on day 1, then inject 40mg SC on day 8, and inject 40mg SC on day 22 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 40mg SC every 2 weeks <input type="checkbox"/> <u>Induction Dose:</u> Inject 160mg SC on day 1, then inject 80mg SC on day 15 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 40mg SC once weekly <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 80mg SC every other week <input type="checkbox"/> Other: _____	3 3	0 0
<input type="checkbox"/> ILUMYA	<input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> <u>Induction Dose:</u> Inject 100mg SC at week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 100mg SC every 12 weeks	2	0
<input type="checkbox"/> NEMLUVIO Weight: _____	<input type="checkbox"/> 30mg Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject 60mg SC on day 1 <input type="checkbox"/> <u>Maintenance Dose</u> (<90kg): Inject 30mg SC every 4 weeks <input type="checkbox"/> <u>Maintenance Dose</u> (>90kg): Inject 60mg SC every 4 weeks	2	0

### PRESCRIPTION SIGNATURE

Dispense as Written: \_\_\_\_\_ Substitution Permitted: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Blue Sky Specialty Pharmacy and its 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 payer

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