Across Specialty Pharmacy

Dermatology Referral Form

Phone: (770) 723 9460
Fax: (770) 723 9461

First Dose Given By: ☐ Provider/Clinic ☐ Patient ☐ Home Health — Date Shipment Needed:

PATIENT INFORMATION				DOCTOR INFORMATION	INJECTION TRAINING: ☐Office ☐ Specialty Pharmacy		
Patient Name:				Prescriber:			
Street Address:				NPI:		Specialty:	☐ Dermatologist ☐ Other ______
City, State, Zip:				Street Address:			
Phone #1:		Phone #2:		City, State, Zip:			
Height: ______	Weight: ______	Sex:	☐ Male ☐ Female	Office Phone:		Office Fax:	
Date of Birth:		Allergies:		Primary Contact:			
Comorbidities:				Email:			

INSURANCE INFORMATION

Insurance Plan Type:	Identification Number:
Processor Control No. (PCN): Rx BIN:	Rx Group:

PLEASE SEND PROGRESS NOTES FOR DOCUMENTATION

New Therapy ☐ Renewal Therapy If Renewal: Date Therapy Initiated:________________

Diagnosis ICD 10:________________**Other:** ____________________
Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa
☐ TB test performed? ☐ Yes ☐ No Date of Neg. Test ☐ Yes ☐ No
☐ HBV ruled out? ☐ Yes ☐ No Does patient have active infection? ☐ Yes ☐ No

Does the patient have inadequate response to PUVA or UVB? ☐ Yes ☐ No
Location:
☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails
Other:____________________ **BSA (% is required): ___________%**

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Dose Directions	Refills
☐ Cimzia®	☐ Cimzia Starter Kit (6x200mg PFS) ☐ Prefilled Syringe x2 ☐ Vial x2	☐ **Initial:** Inject 400mg SQ at weeks 0, 2, and 4 ☐ **Maintenance:** Inject_____mg SQ every: ☐ 2 ☐ 4 wks. Qty_______	Refill:
☐ Cosentyx®	☐ 150mg/mL PEN ☐ 150mg/mL PFS	☐ **Initial:** Inject_____mg SQ at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance:** Inject_____mg SQ every 4 weeks Qty_______	Refill:
☐ Dupixent®	☐ 300mg/2mL ☐ Syringe ☐ 200mg/1.14ml ☐ Pen	☐ **Adult:** 600mg SQ on Day 1, then 300mg SQ every other week, starting on Day 15 ☐ **Pediatric:** ____mg SQ on Day 1, _____mg SQ every ______week, starting on Day ____ Qty_______	Refill:
☐ Enbrel®	☐ Mini Cartridge ☐ SureClick ☐ Prefilled Syringe ☐ Vial	☐ **Induction**: Inject (50 mg) SQ twice weekly for three months ☐ **Maintenance**:☐50 mg ☐ 25 mg ☐ Once weekly SQ ☐ Twice weekly SQ Qty: ☐ 8 ☐ 4	Refill:
☐ Ilumya®	☐ Prefilled Syringe	☐ Inject 100 mg/ml SQ at weeks 0, 4 and every 12 weeks thereafter Qty:_______	Refill:
☐ Humira® (Citrate Free)	☐ Pen ☐ Prefilled Syringe ☐ Citrate Free(CF) ☐ Original Formula	☐ **Hidradenitis Suppurativa Starter:** ☐ 160 mg SQ Day 1/ 80 mg SQ Day 15 ☐80 mg SQ Day 1/ 80 mg SQ Day 2/ 80 mg SQ Day 15 ☐ **Psoriasis Starter:** 80 mg SQ Day 1, 40 mg SQ Day 8, 40 mg SQ Day 22 Qty:___ Pack ☐ **Hidradenitis Suppurativa Maintenance:** 40 mg SQ once weekly, beginning Day 29 ☐ Psoriasis Maintenance:40 mg SQ every other week	Refill:
☐ Otezla®	☐ Titration Starter Pack Rx ☐ 30mg Tablet	☐ Take as directed *Only select for Titration Starter Pack* ☐ Take 30 mg PO ONCE daily ☐ Take 30 mg PO TWICE daily Qty:______	Refill:
☐ Siliq®	☐ Prefilled Syringe	☐ **Induction:** Inject 210 mg SQ weeks 0 and 1 ☐ **Maintenance:**Starting at Week 2 of therapy, inject 210 mg SQ every two weeks Qty:______	Refill:
☐ Skyrizi®	☐ 4 X 75 mg/0.83mL Prefilled Syringe	☐ Inject 150 mg (2x75mg syringes) SQ at week 0, 4 every 12 weeks thereafter Qty:______	
☐ Stelara®	☐ 45mg/0.5mL PFS ☐ 90mg/mL PFS	☐ **Initial:** Inject contents of 1 PFS SQ on day 0 and day 28 ☐ **Maintenance:** Inject contents of 1 PFS SQ every 12 weeks Qty:______	Refill:
☐ Taltz®	☐ 80mg/mL PFS ☐ 80mg/mL Autoinjector	☐ **Initial:** Inject 160mg (two 80mg injections) at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10, and 12, then 80mg every 4 weeks ☐ **Maintenance:** Inject 80mg SQ every 4 weeks Qty:______	Refill:
☐ Tremfya®	☐ 100mg/mL PFS ☐ 100mg/mL Autoinjector	☐ Inject 100mg SQ at week 0, 4, and every 8 weeks there after ☐ Inject 100mg SQ every 8 weeks Qty:______	Refill:
☐ Xeljanz / Xeljanz XR	☐ 5MG (60 tabs) ☐ 11MG (30 tabs)	☐ 5mg twice daily (Xeljanz) ☐ 11MG once daily (Xeljanz XR) Qty:______	

OTHER:	STRENGTH:	SIG/DIRECTIONS:	QUANTITY:	REFILL

By signing below, I authorize Across Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

PRESCRIBER SIGNATURE:____ **DATE:**__________________ ☐ **DO NOT SUBSTITUTE**

IMPORTANT NOTICE: This message is intended for use of only the named addressee and may contain information that is proprietary and confidential. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtains instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.