

**DERMATOLOGY ADDITIONAL REFERRAL FORM**

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Start Date

Ship To: ☐ Patient ☐ Office ☐ Other**1. Patient Information:**

Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. # _____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information:Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization^a

Diagnosis IDC 10: ☐ L40.0 Psoriasis vulgaris ☐ L40.8 Other psoriasis ☐ L40.9 Psoriasis, unspecified ☐ L40.5 Psoriatic Arthritis
☐ L73.2 Hidradenitis Suppurativa ☐ Other: _____

TB/PPD Test given: ☐ No ☐ Yes, Date of Neg. Test: _____ HBV Positive: ☐ No ☐ Yes If yes, patient currently treated? ☐ Yes ☐ No

Prior Treatment? ☐ No ☐ Yes (Provide information below) BSA affected (%) _____

Affected areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ Other: _____

Prior Therapy:	Reason for Discontinuation of Therapy:	Approx. Start Date	Approx. End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Prescription Information:

If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Oxsolaren-Ultra [®]	<input type="checkbox"/> 10 mg			
<input type="checkbox"/> Targretin [®] (Capsules)	<input type="checkbox"/> 75 mg capsules			
<input type="checkbox"/> Targretin [®] (Gel)	<input type="checkbox"/> 1% gel	<input type="checkbox"/> Apply gel every other day for 1 week then at weekly intervals increase to once daily; then twice daily, then three times daily, and finally four times daily.		

4. Prescriber and Shipping Information:

Prescriber (print): _____ Office Contact: _____

Preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____

Office Address: _____

Phone: _____ fax: _____ NPI: _____ DEA: _____

Prescriber's Signature: _____ Date: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Patient Support Programs (optional): Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

6. Insurance Information:

Please fax a copy of the insurance card (front & back)

*IMPORTANT NOTICE: this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.