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

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

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
☐ Oxsolaren-Ultra ®	☐ 10 mg			
☐ Targretin® (Capsules)	☐ 75 mg capsules			
☐ Targretin® (Gel)	☐ 1% gel	☐ Apply gel every other day for 1 week than 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 authorizeAccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. **(NO STAMPS)**

5. Patient Support Programs:

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)