DERMATOLOGY 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

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	Dose/Strength	Directions	Quantity	Refills
☐ Cimzia® (Only for PsA)	☐ 200 mg PFS ☐ 200 mg Lyophilized Vial	***Starter:*** ☐ Inject 400 mg Sub-Q at weeks 0,2, and 4 ***Maintenance:*** ☐ Inject 400 mg Sub-Q every 4 weeks ☐ Inject 200 mg Sub-Q every 2 weeks	☐ 1 starter kit (6 x 200mg/mL PFS) ☐ 3 cartons (2x200mg/mL vial/carton) ☐ 1 carton (2 x 200mg/mL) PFS ☐ 1 carton (2 x 200 mg/mL) Vials	
☐ Cosentyx®	☐ 300 mg ☐ 150 mg	***Starter:*** ☐ Inject Sub-Q at weeks 0,1,2,3, and 4 ***Maintenance:*** ☐ Inject Sub-Q every 4 weeks	☐ ___ ☐ ___	
☐ Enbrel®	☐ 50 mg/mL SureClick® Auto injector ☐ 50 mg/mL PFS	***Starter:*** ☐ Inject 50mg Sub-Q twice a week (72-96 hours apart) x 3 months ***Maintenance:*** ☐ Inject 50 mg Sub-Q every week	☐ 2 cartons (4 x 50mg/mL) SureClick® ☐ 2 cartons (4 x 50mg/mL) PFS ☐ 1 carton (4 x 50mg/mL) SureClick® ☐ 1 carton (4 x 50mg/mL) PFS	
☐ Humira® (Plaque Psoriasis)	☐ 40 mg/0.8mL Pen ☐ 40 mg/0.8mL PFS	***Starter:*** ☐ Inject 80 mg Sub-Q Day 1, then 40 mg on Day 8, then 40 mg every 2 weeks thereafter ***Maintenance:*** ☐ 40 mg Sub-Q every 2 weeks	☐ 1 carton (4 x 40mg/0.8mL) Pens ☐ 2 cartons (2 x 40mg/0.8mL) PFS ☐ 1 carton (2 x 40mg/0.8mL) Pens ☐ 1 carton (2 x 40mg/0.8mL) PFS	
☐ Humira® (Hidradenitis Suppurativa)	☐ 40 mg/0.8mL Pen ☐ 40 mg/0.8mL PFS	***Starter:*** ☐ Inject 160 mg Sub-Q Day 1 (or 80 mg Sub-Q on Day 1 and Day 2); then 80 mg on Day 15 ***Maintenance:*** ☐ Starting on Day 29, 40 mg Sub-Q every week	☐ 1 carton (6 x 40mg/0.8mL) Pens ☐ 1 carton (6 x 40mg/0.8mL) PFS ☐ 2 cartons (2 x 40mg/0.8mL) Pens ☐ 2 cartons (2 x 40mg/0.8mL) PFS	
☐ Otezla®	☐ 4 week starter pack ☐ 30 mg tablet	***Starter:*** ☐ Day 1: 10mg AM; Day 2: 10mg AM, 10 mg PM; Day 3: 10mg AM, 20mg PM; Day 4: 20mg AM, 20mg PM; Day 5: 20mg AM, 30mg PM; Day 6: and thereafter 30 mg twice daily PO ***Maintenance:*** ☐ Take 30 mg twice daily by mouth ☐ **Other**____	☐ 4 week starter pack **(55 tablets)** ☐ **Other** _____ ☐ 60 Tablets ☐ Other_____	
☐ Simponi® (Only for PsA)	☐ 50 mg/0.5mL Pens ☐ 50 mg/0.5mL PFS	☐ Inject 50 mg Sub-Q once a month	☐ 1 carton (1 x 50 mg/0.5mL) Pens ☐ 1 carton (1 x 50 mg/0.5mL) PFS	
☐ Stelara®	☐ 45 mg/0.5mL PFS ☐ 90 mg/mL PFS	***Starter:*** ☐ Inject 45mg/0.5mL Sub-Q on day 1 (≤ 100 kg) ☐ Inject 90mg/mL Sub-Q on day 1 (>100 kg) ***Maintenance:*** ☐ Inject 45mg/0.5mL Sub-Q on Day 29 & every 12 wks thereafter (≤100kg) ☐ Inject 90mg/mL Sub-Q on Day 29 &every 12 wks thereafter (>100 kg)	☐ one 45 mg/0.5mL PFS ☐ one 90 mg/mL PFS ☐ one 45 mg/0.5mL PFS ☐ one 90 mg/mL PFS	

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)