



866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Dermatology Prescription Referral Form

Send your Rx to:

(optional)

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office () Pick-Up (store location): _____ Injection training by pharmacy?

1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (Prescription and Medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Diagnosis ICD-10 L40 (Plaque Psoriasis) L40 (Psoriasis) L40.5 (Psoriatic) L73.2 (Hidradenitis Supp.) L40.8 (other Psoriasis)
Diagnosis Date: _____ Affected Areas: Palms Soles Head Neck Other: _____

4) Prescription Information

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
<input type="checkbox"/> Cimzia SubQ Kit®	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg	<input type="checkbox"/> Inject 400mg (2 subcutaneous injections of 200mg) initially and at weeks 0, 2 and 4. <input type="checkbox"/> Inject 200mg every other week; 400mg every 4 weeks may be considered.		
<input type="checkbox"/> Cosentyx Sensoready®	<input type="checkbox"/> 150mg/ml	Inject 300mg subcutaneously once weekly at weeks 0, 1, 2, 3, and 4.		
<input type="checkbox"/> Dupixent® (dupilumab)	<input type="checkbox"/> 300mg/2ml	Atopic dermatitis: Inject 600mg subcutaneously (given as 2 injections of 300mg each). Then, inject 300mg subcutaneously once every other week.		
<input type="checkbox"/> Enbrel® (etanercept)	<input type="checkbox"/> 25mg/0.5ml <input type="checkbox"/> 50mg/ml	<input type="checkbox"/> Inject 50mg subcutaneously twice weekly for 3 months. <input type="checkbox"/> Inject 50mg subcutaneously once weekly.		
<input type="checkbox"/> Enbrel Peds®	<input type="checkbox"/> 25mg/0.5ml PFS <input type="checkbox"/> 50mg/ml Sureclick	<input type="checkbox"/> Inject 0.8mg/kg subcutaneously (patient <63 kg) once weekly. <input type="checkbox"/> Inject 50mg subcutaneously (patient >63 kg) once weekly.		
<input type="checkbox"/> Humira® (adalimumab)	<input type="checkbox"/> 10/0.2ml Pen <input type="checkbox"/> 20/0.4ml Prefill <input type="checkbox"/> 40/0.8ml Syr	<input type="checkbox"/> Plaque psoriasis: Inject 80mg subcutaneously as a single dose. Inject 40mg subcutaneously every other week starting 1 week after the initial dose. <input type="checkbox"/> Hidradenitis suppurativa (Humira only): Inject 160mg subcutaneously (on day 1) followed by 80mg subcutaneously 2 weeks later (day 15). Inject 40mg subcutaneously (every week beginning on day 29).		
<input type="checkbox"/> Juvederm Volbella XC®	<input type="checkbox"/> gel: 15mg/ml <input type="checkbox"/> inj: 17.5mg/ml PFS	<input type="checkbox"/> Inject Facial Wrinkle: 20ml/60kg/year.		
<input type="checkbox"/> Orencia® (abatacept)	PFS Clickject	<input type="checkbox"/> Infuse _____ mg at weeks 0, 2 and 4. Then every 4 weeks after. <input type="checkbox"/> Inject 125mg subcutaneously once a week.		
<input type="checkbox"/> Otezla® (apremilast)	<input type="checkbox"/> 10mg Tab <input type="checkbox"/> 20mg Therapy <input type="checkbox"/> 30mg Pack	10mg in the morning on day 1. Then 10mg/day on days 2 to 5 as follows: Day 2: 10mg twice daily; Day 3: 10mg in the morning and 20mg in the evening; Day 4: 20mg twice daily; Day 5: 20mg in the morning and 30mg in the evening. 30mg twice daily starting on day 6.		
<input type="checkbox"/> Simponi® (golimumab)	Autoinject PFS	Inject 50mg subcutaneously once per month.		
<input type="checkbox"/> Stelara® (ustekinumab)	<input type="checkbox"/> 45mg/0.5ml PFS <input type="checkbox"/> 90 mg/ml	<input type="checkbox"/> Inject 45mg subcutaneously initially and 4 weeks later, and then 45mg every 12 weeks thereafter. Can be given with or without MTX. Coexistent moderate to severe plaque psoriasis and weight more than 100 kg: Inject 90mg subcutaneously initially and 4 weeks later. Then 90mg every 12 weeks thereafter. <input type="checkbox"/> Peds off label - Plaque psoriasis (off-label) > 12years. <60 kg 0.75mg/kg subcutaneously at 0 and 4 weeks, and then every 12 weeks thereafter. 60 kg -100 kg 45mg subcutaneously at 0 and 4 weeks, and then every 12 weeks thereafter. >100 kg 90mg subcutaneously at 0 and 4 weeks, and then every 12 weeks thereafter.		
<input type="checkbox"/> Tremfya® (guselkumab)	<input type="checkbox"/> 100mg/ml PFS	<input type="checkbox"/> Inject 100mg subcutaneously at weeks 0, 4, and then every 8 weeks thereafter.		

5) Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature Date

6) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

#of Prescriptions