**Priority Health Pharmacy**
Phone: 845-789-5648
Fax: 845-789-4104
NCDPD: 5851476
NPI: 1457297335

# DERMATOLOGY (A-F) REFERRAL FORM



Updated July 2019

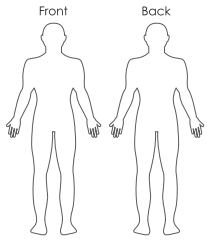
**Patient Name** _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

***Please Fax Insurance Card(s) both sides***
**Insured's Name** _____
Relation to Patient _____
**Primary** Insurance _____
ID# _____ Group # _____
**Secondary** Insurance _____
ID# _____ Group # _____

**Ordering Prescriber** _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

**ICD-10 Code** ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **L73.2** Hidradenitis Suppurativa
☐ **Yes** ☐ **No** Currently on therapy? ☐ **Yes** ☐ **No** Active TB ruled out? Date _____
☐ **Yes** ☐ **No** Active Hep B ruled out? Date_____
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

| Previous Meds | Strength | Duration of Treatment | Not Tolerated | Contraindications |
|---|---|---|---|---|
| Acitretin | | | | |
| Adalimumab | | | | |
| Clobetasol | | | | |
| Cyclosporine | | | | |
| Elidel | | | | |
| Enbrel | | | | |
| Eucrisa | | | | |
| Humira | | | | |
| Leflunomide | | | | |
| Methotrexate | | | | |
| Stelara | | | | |
| Sulfasalazine | | | | |
| UVA Phototherapy | | | | |
| UVB Phototherapy | | | | |




**Scoring Tool Used:**
☐ BSA ☐ EASI ☐ ISGA
☐ POEM ☐ SCORAD
_____% or Score: _____

**Severity:**
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

**Location/Affected Areas:**
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

## PRESCRIPTION

☐ **CIMZIA**
☐ **Starter dose**: 400 mg SQ initially and at weeks 2 & 4 QTY: 6 Refills: 0
**Maintenance dose**:
☐ 200 mg subcutaneously every 2 weeks **OR**
☐ 400 mg subcutaneously every 4 weeks QTY: _____ Refills: _____
**Plaque Psoriasis:** ☐ 400 mg subcutaneously every other week.
*For patients with weight ≤ 90 kg: a dose of 400 mg subcutaneously initially and at Weeks 2 and 4, followed by 200 mg subcutaneously every other week*
QTY: _____ Refills: _____

**COSENTYX** ***New York Prescribers, please submit prescription on an original NY State prescription blank.***
**Starting Dose** ☐ Sensoready® Pen ☐ Prefilled Syringe
*Weeks 0, 1, 2, 3, & 4, then once every 4 weeks*
☐ SIG: Inject 300 mg dose subcutaneously once weekly for 5 weeks
***Each 300 mg dose is given as 2 SQ injections of 150 mg***
QTY: 10 injection devices Refills: 0
**Maintenance Supply** ☐ Sensoready® Pen ☐ Prefilled Syringe
*Once every 4 weeks*
☐ SIG: Inject 300 mg dose subcutaneously once every 4 weeks
***Each 300 mg dose is given as 2 SQ injections of 150 mg***
☐ Other: _____
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY:_____ Refills: _____

☐ **DUPIXENT®** **300 mg/2 mL solution in a single-dose PFS**
☐ Initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week
QTY:_____ Refills: _____

☐ **ENBREL** **50 mg/ml** *not to be used in pediatric weighing less than 63 kg (138 lbs)*
☐ SureClick (prefilled autoinjector) ☐ PFS ☐ Enbrel Mini™/AutoTouch
☐ **Starting Dose:** 50 mg subcutaneously BIW *(72-96 hours apart)*
QTY: 8 Refills _____
*Psoriasis: The recommended starting adult dose is for 3 months
*(Max of 2 refills), please specify number of refills*
☐ **Maintenance Dose:** 50 mg subcutaneously weekly QTY: 4 Refills _____

☐ **ENBREL** **25 mg/ml** *not to be used in pediatric weighing less than 31 kg (68 lbs)*
☐ 25 mg Multiple-Use ☐ 25 mg/0.5 ml PFS
☐ Vial 25 mg subcutaneously BIW *(72-96 hrs apart)*
QTY: 8 Refills: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

**Prescriber's Signature** (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

**Priority Health Pharmacy**
Phone: 845-789-5648
Fax: 845-789-4104
NCDPD: 5851476
NPI: 1457297335

# DERMATOLOGY (G-R) REFERRAL FORM



Updated July 2019

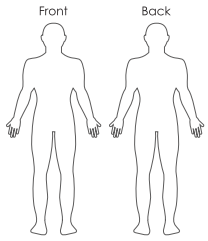
**Patient Name** _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

***Please Fax Insurance Card(s) both sides***
**Insured's Name** _____
Relation to Patient _____
**Primary** Insurance _____
ID# _____ Group # _____
**Secondary** Insurance _____
ID# _____ Group # _____

**Ordering Prescriber** _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

**ICD-10 Code** ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **L73.2** Hidradenitis Suppurativa
☐ **Yes** ☐ **No** Currently on therapy?
☐ **Yes** ☐ **No** Active Hep B ruled out? Date_____
☐ **Yes** ☐ **No** Active TB ruled out? Date _____
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

| Previous Meds | Strength | Duration of Treatment | Not Tolerated | Contraindications |
|---|---|---|---|---|
| Acitretin | | | | |
| Adalimumab | | | | |
| Clobetasol | | | | |
| Cyclosporine | | | | |
| Elidel | | | | |
| Enbrel | | | | |
| Eucrisa | | | | |
| Humira | | | | |
| Leflunomide | | | | |
| Methotrexate | | | | |
| Stelara | | | | |
| Sulfasalazine | | | | |
| UVA Phototherapy | | | | |
| UVB Phototherapy | | | | |




**Scoring Tool Used:**
☐ BSA ☐ EASI ☐ ISGA
☐ POEM ☐ SCORAD
_____% or Score: _____

**Severity:**
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

**Location/Affected Areas:**
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

## PRESCRIPTION

*Psoriasis* ☐ **HUMIRA** 80 mg/0.8mL | ☐ PFS ☐ Pens
☐ **HUMIRA Citrate-Free** **Dose:** ☐ 40 mg/0.4mL | ☐ PFS ☐ Pens
☐ **Starting Dose:** Inject 80 mg initial dose subcutaneously on day 1, followed by 40 mg every other week starting one week after initial dose QTY:_____ NO REFILLS
☐ **Maintenance Dose:** Inject 40 mg subcutaneously every other week QTY:_____ Refills: _____

*Hidradenitis Suppurativa* ☐ **HUMIRA** ☐ **HUMIRA Citrate-Free**
**Dose:** ☐ 40 mg/0.8mL ☐ 80 mg/0.8mL | ☐ PFS ☐ Pens
☐ **Starting Dose:** Inject four 40 mg pens/syringes subcutaneously on day 1 OR inject two 40 mg pen/syringes daily for 2 days, THEN two 40mg pens/syringes on day 15, QTY: 6 NO REFILLS
☐ **Maintenance Dose:** Inject 40 mg subcutaneously every week, beginning day 29 QTY:_____ Refills: _____

☐ **RASUVO®**
☐ 10mg ☐ 12.5mg ☐ 15mg
☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg
SIG: Inject _____mg subcutaneously weekly QTY: 4 Refill: _____

☐ **ILUMYA 100mg/mL PFS**
☐ **Starting Dose:** Initial dose of 100 mg subcutaneous injection at week 0 and week 4 QTY: 2 Refills: 0
☐ **Maintenance Dose:** 100 mg subcutaneous injection given every 12 weeks thereafter QTY: 1 Refills: _____
****ILUMYA should only be administered by a healthcare provider****

☐ **OTEZLA®**
☐ **Titration Starter Pack**
SIG: Take as directed QTY: 55 for 28 days
☐ **Maintenance**: 30 mg
SIG: Take 30 mg twice a day QTY: 60 Refills: _____

☐ **OTEZLA® Bridge Rx 30 mg**
☐ SIG: Take 30 mg twice a day for 14 days QTY: 28 Refills: 12
☐ SIG: Take 30 mg once a day for 28 days QTY: 28 Refills: 6
****For direct to manufacture program ONLY****

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

**Prescriber's Signature** (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

**Priority Health Pharmacy**
Phone: 845-789-5648
Fax: 845-789-4104
NCDPD: 5851476
NPI: 1457297335

# DERMATOLOGY (S-Z) REFERRAL FORM



Updated July 2019

**Patient Name** _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

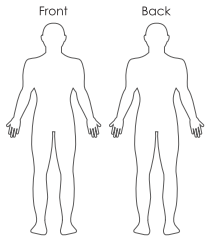
***Please Fax Insurance Card(s) both sides***

**Insured's Name** _____
Relation to Patient _____
**Primary** Insurance _____
ID# _____ Group # _____
**Secondary** Insurance _____
ID# _____ Group # _____

**Ordering Prescriber** _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

**ICD-10 Code** ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **L73.2** Hidradenitis Suppurativa
☐ **Yes** ☐ **No** Currently on therapy? ☐ **Yes** ☐ **No** Active TB ruled out? Date _____
☐ **Yes** ☐ **No** Active Hep B ruled out? Date_____
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

| Previous Meds | Strength | Duration of Treatment | Not Tolerated | Contraindications |
|---|---|---|---|---|
| Acitretin | | | | |
| Adalimumab | | | | |
| Clobetasol | | | | |
| Cyclosporine | | | | |
| Elidel | | | | |
| Enbrel | | | | |
| Eucrisa | | | | |
| Humira | | | | |
| Leflunomide | | | | |
| Methotrexate | | | | |
| Stelara | | | | |
| Sulfasalazine | | | | |
| UVA Phototherapy | | | | |
| UVB Phototherapy | | | | |




**Scoring Tool Used:**
☐ BSA ☐ EASI ☐ ISGA
☐ POEM ☐ SCORAD
_____% or Score: _____

**Severity:**
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

**Location/Affected Areas:**
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

## PRESCRIPTION

☐ **SILIQ 210 mg/mL** PFS
☐ **Initial dose:** Inject 210 mg SQ on weeks 0, 1, and 2 QTY: 2 Refills: 0
☐ **Maintenance Dose:** Inject 210 mg subcutaneously every 2 weeks thereafter QTY: 2 Refills: _____

*Psoriatic Arthritis* ☐ **SIMPONI®**
☐ **50 mg/0.5ml SmartJect™ (Autoinjector)**
Sig: Inject 1 single-use Autoinjector SQ once monthly QTY: 1 Refills: _____
☐ **50 mg/0.5mL PFS**
Sig: Inject 1 single-use PFS SQ once monthly QTY: 1 Refills: _____

*Plaque Psoriasis* ☐ **SKYRIZI 75 mg/0.83 mL PFS**
☐ **Start Dose:** Inject 150mg (two 75 mg injections) subcutaneously at week 0, week 4 QTY: 4 Refills: 0
☐ **Maintenance Dose:** Inject 150mg (two 75 mg injections) subcutaneously every 12 weeks thereafter QTY: _____ Refills: _____

**STELARA** ☐ **45 mg** OR ☐ **90mg**
☐ **Start Dose:** Inject ____ mg subcutaneously initially and 4 weeks later QTY: 2 Refills: _____
☐ **Maintenance Dose:** Inject ____ mg subcutaneously every 12 weeks QTY: 1 Refills: _____

☐ **TREMFYA 100 mg/mL PFS**
☐ **Initial dose:** 100 mg subcutaneous injection at week 0 and week 4
☐ **Maint Dose:** 100 mg subcutaneous injection given every 8 weeks thereafter QTY: _____ Refills: _____

*Psoriasis* **TALTZ 80mg/mL** ☐ Autoinjector ☐ Prefilled Syringe
☐ **Start Dose:** Inject 160mg SQ on Day 1 QTY: 2 pens Refills: 0
☐ **Induction Dose:** Inject 80 mg subcutaneously starting week 2 and every 2 weeks through week 12 QTY: 6 pens Refills: 0
☐ **Maintenance Dose:** Inject 80mg subcutaneously every 4 weeks QTY: 1 pen Refills: ____

*Psoriatic Arthritis* **TALTZ 80mg/mL** ☐ Autoinjector ☐ Prefilled Syringe
☐ **Start Dose:** Inject 160 mg SQ at week 0 QTY: 2 Refills: 0
☐ **Maint Dose:** Inject 80mg SQ every 4 weeks QTY: ____ Refills: ____

*Psoriatic Arthritis* **XELJANZ®** ☐ 5 mg tab **XELJANZ XR®** ☐ 11 mg tab
Used in combination with nonbiologic DMARDs:
☐ 5 mg twice daily OR ☐ 11 mg once daily QTY: _____ Refills: _____
☐ Other: _____ QTY: _____ Refills: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

**Prescriber's Signature** (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.