

# DERMATOLOGY REFERRAL FORM

# I-Z

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Pharmacy  
HyVee SOLUTIONS

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Latex Allergy Yes No			
Sex	Male	Female	Weight (kg)		Height (ft,in)		Prescriber NPI		
Insurance Plan			Plan ID #			Nurse/Key Contact		Phone/Pager	
						Fax		Email	

## Diagnosis/Clinical Information

Diagnosis: L20.\_\_\_\_ Atopic Dermatitis      L40.0 Psoriasis vulgaris/Plaque psoriasis/Nummular psoriasis      L40.8 Other psoriasis  
 L40.9 Psoriasis, unspecified      L40.5 \_\_\_\_ Psoriatic arthritis      L73.2 Hidradenitis Suppurativa      Other: \_\_\_\_\_

Date of diagnosis or years with the disease: \_\_\_\_\_

Active TB is ruled out: Yes No      Date of negative TB test: \_\_\_\_/\_\_\_\_/\_\_\_\_

Concomitant medications: \_\_\_\_\_

Previous treatment regimens with dates and reason for discontinuation: \_\_\_\_\_

## Prescription Information

MEDICATION		DOSE/STRENGTH/DIRECTIONS FOR USE		QTY	REFILLS
Remicade® Weight ____kg Biosimilars: Inflectra® Renflexis®	Vial	Starter dose: 5mg/kg (____mg) IV at weeks 0, 2 and 6		Q5	0
		Maintenance dose: 5mg/kg(____mg) IV every 8 weeks		56 day	_____
Siliq®	PFS	Starter dose: Inject 210mg SC on weeks 0, 1 and 2, inject 210mg SC every 2 weeks thereafter		4 x 210mg/1.5ml	0
		Maintenance dose: Inject 210mg SC every 2 weeks		2 x 210mg/1.5ml	_____
Simponi®	SmartJect Autoinjector PFS	Inject 50mg SC once a month		1 x 50mg/0.5ml	_____
Stelara® Weight ____kg	PFS	Starter dose: Inject 45mg SC on Day 1 (≤100 kg)		1 x 45mg/0.5ml	0
		Starter dose: Inject 90mg SC on Day 1 (>100 kg)		1 x 90mg/ml	
		Maintenance dose: Inject 45mg SC on Day 29 and every 12 weeks thereafter (≤100 kg)		1 x 45mg/0.5ml	_____
Maintenance dose: Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100 kg)		1 x 90mg/ml			
Taltz®	Autoinjector PFS	Starter dose: Inject 160mg (2 x 80mg) SC at week 0, then inject 80mg SC at week 2		3 x 80mg/ml	0
	Autoinjector PFS	Starter dose: Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10		4 x 80mg/ml	0
	Autoinjector PFS	Maintenance dose: Inject 80mg SC at week 12 and every 4 weeks thereafter		1 x 80mg/ml	_____
Tremfya®	PFS	Starter dose: Inject 100mg SC at week 0, then 100mg at week 4 and every 8 weeks thereafter		2 x 100mg/ml	0
		Maintenance dose: Inject 100mg SC every 8 weeks		1 x 100mg/ml	_____
Date needed: ____/____/____ Medication delivery to (choose one): Prescriber Home Other:					
Injection training to be provided by: Prescriber's Office Hy-Vee Pharmacy Solutions Other: _____					

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: \_\_\_\_\_

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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