DERMATOLOGY REFERRAL FORM I-Z

877.RxHyVee (877.794.9833)
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Pharmacy HyVee SOLUTIONS

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
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	☐ QS	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) ☐ Starter dose: Inject 90mg SC on Day 1 (>100 kg)	☐ 1 x 45mg/0.5ml ☐ 1 x 90mg/ml	0
		☐ Maintenance dose: Inject 45mg SC on Day 29 and every 12 weeks thereafter (≤100 kg) ☐ Maintenance dose: Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100 kg)	☐ 1 x 45mg/0.5ml ☐ 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)