DERMATOLOGY REFERRAL FORM O-Z

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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
PLEASE FAX CLINICAL AND LAB 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
Otezla®	28-day starter pack	Titration dose: Take as directed per package instructions	55 tablets	0
	Tablets	Bridge dose: Take 30mg by mouth once daily Bridge dose: Take 30mg by mouth twice daily	28	______
		Maintenance dose: Take 30mg by mouth once daily Maintenance dose: Take 30mg by mouth twice daily	30-day supply	
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)

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