DERMATOLOGY REFERRAL FORM A-H

877.RxHyVee (877.794.9833)
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Hy-Vee Pharmacy 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
☐ **Cimzia®**	☐ PFS ☐ Vials	☐ Starter dose: Inject 400mg SC at weeks 0, 2 and 4	☐ 6 x 200mg/ml	0
		☐ Maintenance dose: Inject 200mg SC every 2 weeks ☐ Maintenance dose: Inject 400mg SC every 4 weeks	☐ 2 x 200mg/ml	_____
☐ **Cosentyx®**	☐ Sensoready Pen ☐ PFS	☐ Starter dose: Inject 150mg SC once weekly at weeks 0, 1, 2 and 3 ☐ Starter dose: Inject 300mg SC once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150mg/ml ☐ 8 x 150mg/ml	0
		☐ Maintenance dose: Inject 150mg SC on week 4 and every 4 weeks thereafter ☐ Maintenance dose: Inject 300mg SC on week 4 and every 4 weeks thereafter	☐ 1 x 150mg/ml ☐ 2 x 150mg/ml	_____
☐ **Dupixent®**	☐ PFS	☐ Starter dose: Inject 600mg SC on day 1, followed by 300mg SC at day 15 and every 2 weeks thereafter	☐ 4 x 300mg/2ml	0
		☐ Maintenance dose: Inject 300mg SC every 2 weeks	☐ 2 x 300mg/2ml	_____
☐ **Enbrel®** Adult	☐ SureClick Autoinjector ☐ PFS ☐ Enbrel® Mini	☐ Starter dose: Inject 50mg SC twice a week (72-96 hours apart) for 3 months	☐ 8 x 50mg/ml	2
		☐ Maintenance dose: Inject 50mg SC every week	☐ 4 x 50mg/ml	_____
☐ **Enbrel®** Pediatric ≥4yo	☐ Vials ☐ PFS	☐ Inject _____mg (0.8mg/kg) SC every week (<63 kg)	☐ _____ x 25mg	_____
Weight _____kg	☐ SureClick Autoinjector ☐ PFS ☐ Enbrel® Mini	☐ Inject 50mg SC every week (≥63kg)	☐ 4 x 50mg	_____
☐ **Humira®**	☐ Pens ☐ PFS	☐ Plaque psoriasis (starter dose): Inject 80mg SC day 1, then 40mg SC on day 8, then 40mg every 2 weeks ☐ Hidradenitis Suppurativa (starter dose): Inject 160mg SC on day 1, then 80mg on day 15 then 40mg SC on day 29 and every week thereafter	☐ 4 x 40mg/0.8ml ☐ 6 x 40mg/0.8ml	0
☐ **Humira® Induction Dose (Citrate-Free)**	☐ Pens ☐ PFS	☐ Plaque psoriasis (starter dose): Inject 80mg SC day 1, then 40mg SC on day 8, then 40mg every 2 weeks	☐ 1 KIT of 1 x 80mg/0.8mL, 2 x 40mg/0.4mL	0
		☐ Hidradenitis Suppurativa (starter dose): Inject 160mg SC on day 1, 80mg on day 15, then 40mg SC on day 29 and every week thereafter	☐ 1 KIT of 3 x 80mg/0.8mL	0
☐ **Humira® MAINTENANCE DOSE**	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL Pen (Citrate-free) ☐ 40mg/0.4mL PFS (Citrate-free)	☐ Plaque Psoriasis (maintenance dose) 40mg SC injection EVERY OTHER week ☐ Hidradenitis Suppurativa (maintenance dose) 40mg SC injection EVERY week ☐ Other: _____	☐ #2 ☐ #4 ☐ # _____	_____ _____ _____

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)