Dermatology Prescription Referral Form

Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy
www.rosemontspecialtyrx.com

Date Medication Needed: _____ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up

1: Patient Information | **Insurance Information:** Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Patient Name: _____ Birthdate: _____ Sex: ○ Male ○ Female Height: _____ Weight: _____ ○ lbs. ○ kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

2: Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis:

Date of Diagnosis (or years with disease): _____

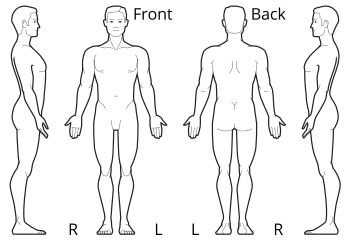
Has patient been treated previously for this condition? ○ Yes ○ No

If yes, medication/therapy failed (length of therapy): _____

Has Patient received PPD (tuberculosis) Skin Test? ○ Yes ○ No

Has Hepatitis B been ruled out or treatment been initiated? ○ Yes ○ No

Does patient have a latex allergy? ○ Yes ○ No



_____ % BSA affected by Psoriasis

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Cosentyx®**	☐ 300mg OR 150mg Sensoready Pen OR Prefilled Syringe	☐ **Starter Dose:** Inject SC at weeks 0, 1, 2, 3 and 4 ☐ **Maintenance Dose:** Inject SC every 4 weeks ☐ **Other:** _____		0
☐ **Dupixent®**	☐ 300mg/2mL Prefilled Syringe	☐ **Starter Dose:** ☐ 600mg SC divided in 2 different injection sites ☐ **Maintenance Dose:** ☐ 300mg SC every other week	2 2	0
☐ **Enbrel®**	☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml SureClick™ Autoinjector ☐ 25mg/0.5ml Prefilled Syringe	☐ **Starter Dose:** Inject 50mg SC TWICE a week *(72-96 hours apart for three months)* ☐ **Maintenance Dose:** Inject 50mg SC ONCE a week ☐ **Other:** _____		
☐ **Humira®** ☐ Injection training from My Humira ***(patient must sign below)***	☐ 20mg/0.4ml Prefilled Syringe *(2 doses)* ☐ 40mg/0.8ml Pen (2 doses) ☐ 40mg/0.8ml Prefilled Syringe *(2 doses)* ☐ 40mg Kit 4x0.8ml ☐ 40mg Starter Kit 6x0.8ml	**Starter Dose:** ☐ Hidradenitis Suppurativa: Inject 160mg SC in day 1, then 80mg on day 15 ☐ Plaque Psoriasis; Inject 80mg SC day 1, then 40mg on day 8, and then 40mg every 2 weeks thereafter ☐ Other: _____ **Maintenance Dose:** ☐ Hidradenitis Suppurativa: Inject 40mg SC on day 29 and then every week thereafter ☐ Plaque Psoriasis; Inject 40mg SC every 2 weeks		0 refills for Starter dose
☐ **Otezla®**	*Please use Otezla-specific referral form available at **avella.com/forms***			
☐ **Siliq®**	☐ 210mg/1.5mL Prefilled Syringe	☐ **Starter Dose:** ☐ 210mg SC on weeks 0, 1, 2 ☐ **Maintenance Dose:** ☐ 210mg SC every 2 weeks		0
☐ **Stelara®**	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/1ml Prefilled Syringe	**Starter Dose:** ☐ Inject 45mg SC **(patient ≤100 kg)** at Day 1 ☐ Inject 90mg SC **(patient >100 kg)** at Day 1 **Maintenance Dose:** ☐ Inject 45mg SC **(patient ≤100 kg)** *On Day 29 and then every 12 weeks* ☐ Inject 90mg SC **(patient >100 kg)** *On Day 29 and then every 12 weeks* ☐ Other: _____	☐ Initial Dose: 1 ☐ Other:	
☐ **Taltz®**	☐ Autoinjector 80mg/mL ☐ Prefilled Syringe 80mg/mL	☐ **Starter Dose:** 160mg SQ at week 0; then inject 80mg SQ at weeks 2,4,6,8,10 & 12 ☐ **Maintenance Dose:** 80mg SQ every 4 weeks		
☐ **Tremfya®**	☐ 100mg/ml Prefilled Syringe	☐ **Starter Dose:** Inject 100mg SC at weeks *0 & 4* ☐ **Maintenance Dose:** Inject 100mg SQ every 8 weeks		
☐ **Valchlor™**	☐ 0.016% gel	Apply a thin film once daily to the affected aread of the body. Directions, if different from above: _____		

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

I authorize Rosemont Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

# of Prescriptions: _____