Dermatology Form 1
Prescription Referral Form
ESCRIBE #: 5700174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

URAC ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Sig	Qty	Refills
☐ **Cosentyx®**	☐ 300mg ☐ 150mg Sensoready Pen OR Prefilled Syringe	☐ Starter Dose: Inject 300mg SC at weeks 0, 1, 2, 3 and 4 ☐ Maintenance Dose: Inject 300mg 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 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 3 months) ☐ Maintenance Dose: Inject 50mg SC ONCE a week		
☐ **Humira®** ☐ **Humira® Citrate-Free**	☐ 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
☐ **Siliq®**	☐ 210mg/1.5mL Prefilled Syringe	☐ Starter Dose: 210mg SC on weeks 0, 1, and 2, then maintenance thereafter ☐ Maintenance Dose: 210mg SC every 2 weeks		
☐ **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: _____	☐ 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 areas of the body. ☐ Other: _____		

Ship to: ☐ Patient ☐ Office ☐ Other

4. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.