ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

DERMATOLOGY REFERRAL FORM

Date Needed _____

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current Medications (if necessary, please fax a complete list)_____

Primary Insurance _____ Member ID _____
RxBIN _____ Rx PCN _____ Rx Grp _____
Member Services Number _____ Provider Services Number _____

ICD-10 Diagnosis Code: ☐ L40.59 Psoriatic Arthritis ☐ L40.8 Psoriasis ☐ L20.____ Atopic Dermatitis ☐ Other _____
PPD (TB Test) ☐ Yes ☐ No Date_____ Does patient have latex allergy (for Enbrel)? ☐ Yes ☐ No
_____% BSA (body surface area) affected by Psoriasis Weight _____ lb or _____Kg
Methotrexate contraindicated: Due to social activities? ☐ Yes ☐ No Because patient is of child bearing age? ☐ Yes ☐ No
Previously treated for this condition? ☐ Yes ☐ No Please indicate failed medication(s) below

	Medication	Strength	Duration of Treatment/ Reason for Discontinuation
Biologics	Adalimumab		
	Alefacept		
	Etananercept		
	Efalizumab		
Topical Meds	Calcipotriene		
	Cyclosporine		
	Tazarotene		

	Medication	Strength	Duration of Treatment/ Reason for Discontinuation
Oral Meds	Acitretin		
	Corticosteroids (oral)		
	Cyclosporine		
	Methotrexate		
	NSAID		
	Sulfasalazine		
Phototherapy	PUVA		
	UVB		

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

DUPIXENT® ☐ 300 mg/2 mL solution Prefilled Syringe
☐ **Starting Dose:** Inject 600mg (two 300mg injections in different injection sites initially). Then inject 300mg (1 PFS) on day 15 and then inject 300mg (1 PFS) on day 29. QTY: 4 Refill: _____
☐ **Maintenance Dose:** Inject 300mg every other week. QTY: _____ Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *MyWay™*

ILUMYA™ ☐ Prefilled Syringe 100mg/mL
☐ **Starting Dose:** Initial dose of 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 12 weeks thereafter. QTY: ____ Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *ILUMYA SUPPORT™*

SILIQ™ ☐ 210 mg/1.5 mL PFS
☐ Induction Dose: Inject 210 mg of SILIQ at Weeks 0, 1, and 2 then maint. QTY: 3 Refill: _____
☐ Maintenance Dose: Inject 210 mg of SILIQ every 2 weeks QTY: 2 Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Siliq Solutions™*

TREMFYA™ ☐ Prefilled Syringe 100mg/mL
☐ **Starting Dose:** Initial dose of 100 mg SQ injection at week 0 and week 4
☐ **Maintenance Dose:** 100 mg SQ injection given every 8 weeks thereafter. QTY: ____ Refill: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Janssen CarePath*

COSENTYX® ☐ 150 mg Sensoready® Pen ☐ 150 mg Prefilled Syringe
☐ **Starting Dose:** Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ once weekly for 5 weeks (Each 300 mg dose is given as 2 SQ injections of 150 mg)
QTY: 10 injection devices Refills: 0
☐ Inject 150 mg dose once weekly for 5 weeks QTY: 5 injection devices Refills: 0
☐ **Maintenance Supply:** Once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ once every 4 weeks (Each 300 mg dose is given as 2 SQ injections of 150 mg)
☐ Inject 150 mg dose SQ once every 4 weeks
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Cosentyx® Connect*

HUMIRA® and HUMIRA Citrate-Free® *Patient weight (kg)*_____
Psoriasis Starter: ☐ 80mg/0.8ml + 40mg/0.4ml citrate-free Pen Psoriasis Starter Kit (3-ct)
☐ 40mg/0.8ml Pen Original Psoriasis Starter Kit (4-ct)
SIG: Inject 80mg SQ on Day 1, then inject 40mg SQ on Day 8, then inject 40mg SQ every other week. QTY: 1 Kit Refills: 0
HS Starter: ☐ 80mg/0.8ml citrate-free Pen Hidradenitis Suppurativa Starter Kit (3-ct)
☐ 40mg/0.8ml Pen Hidradenitis Suppurativa Starter Kit (6-ct)
SIG: Inject 160mg SQ on Day 1, then inject 80mg SQ on Day 15. QTY: 1 Kit Refills: 0
Maintenance: ☐ 40mg/0.4ml citrate-free Pen (2-ct) ☐ 40mg/0.4ml citrate-free PFS (2-ct)
☐ 40mg/0.8ml Pen (2-ct) ☐ 40mg/0.8ml PFS (2-ct)
☐ Psoriasis/Psoriatic Arthritis Sig: Inject 40mg SQ every other week.
☐ Hidradenitis Suppurativa Sig: Inject 40mg SQ every week starting on Day 29.
☐ Other: _____
QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Ambassador Program*

OTHER _____
SIG: _____ QTY: _____ Refill: _____

OTEZLA® ☐ Prescriber Provided 2 Week Starter Pack Sample
☐ 28-Day Starter Pack ☐ Maintenance
Dose: ☐ Take As Directed *Only available for the 28 day Starter Pack* QTY: 55 Refill: 0
☐ Take 30 mg once daily QTY: 30 Refill: _____
☐ Take 30 mg twice daily QTY: 60 Refill: _____
☐ If applicable, enroll patient in *Otezla SupportPlus™*

TALTZ® 80mg ☐ Autoinjector ☐ Prefilled Syringe
Starting Dose: SIG: ☐ Inject 160mg SQ at week 0 followed by 80mg at weeks 2,4,6,8,10 & 12
QTY: 8 Refills: 0
Maintenance Dose: SIG: ☐ Inject 80mg SQ every 4 weeks QTY: _____ Refills: _____
☐ Other: _____ QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Taltz Together™*

SIMPONI™ ☐ SmartJect™ Autoinjector ☐ PFS 50mg/0.5mL
☐ **Psoriatic Arthritis Dose:** Inject 50 mg (0.5ml) SC once a month QTY: 1 vial Refills: _____
☐ Other: _____ QTY: _____ Refills: _____
SIMPONI ARIA™ ☐ 50mg/4ml (12.5mg/ml) in a single use vial
☐ **Dose:** 2mg/kg intravenous infusion over 30 minutes at wks 0 & 4, then every 8 wks
QTY: 1 vial Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *SimponiOne®*

RASUVO® ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg
☐ Inject _____mg subcutaneously weekly QTY: 4 Refill: _____
☐ If applicable, enroll patient in *CORE Connections*

ENBREL® (etanercept) ☐ SureClick™ Autoinjector 50mg ☐ Prefilled Syringe 50mg
☐ Enbrel Mini™/AutoTouch 50mg ☐ Multiuse Vial 25mg ☐ Prefilled Syringe 25mg/0.5ml
Dispense: ☐ **Psoriasis Induction Dose:** Inject 50mg SC TWICE a week
(3-4 days apart) for 3 months, then maintenance dosing
☐ **Psoriasis Maintenance Dose:** Inject 50mg SC ONCE a week
☐ **Psoriatic Arthritis Dose:** Inject 50mg SC ONCE a week
☐ Other: _____ QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *ENBREL Support™*

STELARA™ *Patient Weight (kg):* _____
Starting Dose: Inject ☐ 45mg (1 PFS) SC for patients weighing <100kg (220lbs)
initially and then 4 weeks later QTY: 2
Maintenance Dose: Inject ☐ 45mg (1 PFS) SC every 12 weeks Refills: _____
Starting Dose: Inject ☐ 90mg (1 PFS) SC for patients weighing >100kg (220lbs)
initially and then 4 weeks later QTY: 2
Maintenance Dose: Inject ☐ 90mg (1 PFS) SC every 12 weeks Refills: _____
☐ Other: _____ QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Janssen CarePath*

REMICADE® ☐ 100mg Vial QTY: _____# of vials Refill_____
☐ Induction Dose: Infuse 5mg/kg in 250mL of 0.9% NaCl at wk 0,wk 2, wk 6, & every 8 wks thereafter
☐ Maintenance Dose: Infuse 5mg/kg in 250ml of 0.9% NaCl every 8 wks
☐ Other: _____
☐ If applicable, enroll patient in *Janssen CarePath*

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS) _____ **Date**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.