DERMATOLOGY REFERRAL FORM

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Albertsons Companies Specialty Care

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Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

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

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia (certolizumab)	☐ Starter Kit 200mg/mL Prefilled Syringe	☐ Loading Dose: Inject 400mg (2 syringes) subcutaneously at weeks 0, 2 and 4.	1 kit (6 syringes)	
	☐ 200mg/mL Prefilled Syringe	☐ Maintenance Dose: Inject 400mg (2 syringes) subcutaneously every 4 weeks.	28-day supply	
		☐ Maintenance Dose: Inject 200mg (1 syringe) subcutaneously every 2 weeks.		
☐ Cosentyx (secukinumab)	☐ 150mg Sensoready Pen	☐ Loading Dose: Inject 150mg subcutaneously once weekly at weeks 0, 1, 2, 3, and 4. ☐ Loading Dose: Inject 300mg (2 injections of 150mg) subcutaneously once weekly at weeks 0, 1, 2, 3, and 4.	5 doses	
	☐ 150mg Prefilled Syringe	☐ Maintenance Dose: Inject 150mg subcutaneously every 4 weeks. ☐ Maintenance Dose: Inject 300mg (2 injections of 150mg) subcutaneously every 4 weeks.	28-day supply	
☐ Dupixent (dupilumab)	☐ 300mg/2mL Prefilled Syringe	☐ Loading Dose: Inject 600mg (given as two 300mg injections in different sites) subcutaneously one time.	2 Syringes	
		☐ Maintenance Dose: Inject 300mg subcutaneoulsy every other week.	28-day supply	
☐ Enbrel (etanercept)	☐ 50mg/mL Sureclick Auto-injector ☐ 50mg/mL Prefilled Syringe	☐ Loading Dose: Inject 50mg subcutaneously twice a week (72-96 hours apart) for 3 months.	28-day supply	
		☐ Maintenance Dose: Inject 50mg subcutaneously once a week.	28-day supply	
☐ Humira (adalimumab)	☐ Citrate-free Psoriasis Starter Kit (3 pens) ☐ Psoriasis Starter Kit (4 pens)	☐ Plaque Psoriasis (adult) or Hidradenitis Suppurativa (12 years and older, 30 kg to < 60 kg) Loading Dose: Inject 80mg subcutaneously on day 1, then 40mg on day 8, then 40mg on day 22 and every OTHER week thereafter.	1 kit	
	☐ Citrate-free Hidradenitis Suppurativa Starter Kit (3 pens)	☐ Hidradenitis Suppurativa (adult or 12 years and older, ≥ 60 kg) Loading Dose: Inject 160mg (two 80mg pens) subcutaneously on day 1, then 80mg (one 80mg pen) on day 15, then 40mg (one 40mg pen) on day 29 and once a week thereafter.	28-day supply	
	☐ 40mg/0.4 mL Citrate-free Pen ☐ 40mg/0.8 mL Pen ☐ 40mg/0.4 mL Citrate-free Prefilled Syringe ☐ 40mg/0.8 mL Prefilled Syringe	☐ Plaque Psoriasis (adult) or Hidradenitis Suppurativa (12 years and older, 30 kg to < 60 kg) Maintenance Dose: Inject 40mg subcutaneously on day 22 then every OTHER week thereafter. ☐ Hidradenitis Suppurativa (adult or 12 years and older, ≥ 60 kg) Maintenance Dose: Inject 40mg subcutaneously on day 29 then once a week thereafter.	28-day supply	
☐ Orencia (abatacept)	☐ 250mg Vial (IV use only)	☐ Loading Dose: Administer _____ mg via intravenous infusion at 0, 2 and 4 weeks.	28-day supply	
		☐ Maintenance Dose: Administer ____ mg via intravenous infusion every 4 weeks.		
	☐ 125mg/mL Prefilled Syringe	☐ Inject 125mg subcutaneously once weekly.		

Prescription information continued on next page

Prescription Information - Continued

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Otezla (apremilast)	☐ 14-day Starter Pack ☐ 28-day Starter Pack	☐ Loading Dose: Take 10mg by mouth in the morning on day 1, then take 10mg twice daily on day 2, then take 10mg in the morning and 20mg in the evening on day 3, then take 20mg twice daily on day 4, then take 20mg in the morning and 30mg in the evening on day 5, then take 30mg twice daily on day 6 and thereafter. ☐ Loading Dose (severe renal impairment, CrCL < 30mL/min): Take 10mg by mouth in the morning on days 1, 2 and 3; then take 20mg in the morning on days 4 and 5; then take 30mg in the morning on day 6 and thereafter.	1 pack	
	☐ 30mg Tablet	☐ Maintenance Dose: Take 1 tablet by mouth twice daily.	60	
		☐ Maintenance Dose (severe renal impairment, CrCL < 30mL/min): Take 1 tablet by mouth once daily.	30	
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb)	100mg Vial	Loading Dose: Administer _____ mg (at 5 mg/kg) intravenously at 0, 2 and 6 weeks.	42-day supply	
		Maintenance Dose: Administer _____ mg (at 5mg/kg) intravenously every ___ weeks.	28-day supply	
☐ Siliq (brodalumab)	☐ 210mg/1.5mL Prefilled Syringe	☐ Loading Dose: Inject 210mg (1 syringe) subcutaneously at weeks 0, 1 and 2, then every 2 weeks thereafter.	28-day supply (4 syringes)	
		☐ Maintenance Dose: Inject 210mg (1 syringe) subcutaneously every 2 weeks.	28-day supply	
☐ Simponi (golimumab)	☐ 50mg/0.5mL SmartJect Auto-injector ☐ 50mg/0.5mL Prefilled Syringe	☐ Inject 50mg subcutaneously once a month.	28-day supply	
☐ Stelara (ustekinumab)	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/mL Prefilled Syringe	☐ Loading Dose: Inject the contents of 1 prefilled syringe subcutaneously on Day 1 and then repeat on Day 29.	28-day supply	
		☐ Maintenance Dose: Inject the contents of 1 prefilled syringe subcutaneously every 12 weeks.	12-wk supply	
☐ Taltz (ixekizumab)	☐ 80mg/mL Auto-injector ☐ 80mg/mL Prefilled Syringe	☐ Inject 160mg subcutaneously at weeks 2, 4, 6, 8, 10 and 12; then inject 80mg subcutaneously every 4 weeks. ☐ Inject 160mg subcutaneously once, followed by 80mg subcutaneously every 4 weeks. ☐ Inject 80mg subcutaneously every 4 weeks.	☐ 28-day supply ☐ 84-day supply	
☐ Tremfya (guselkumab)	100mg/mL Prefilled Syringe	☐ Loading Dose: Inject 100mg (1 syringe) subcutaneously at weeks 0 and 4, then every 8 weeks thereafter.	28-day supply	
		☐ Maintenance Dose: Inject 100mg (1 syringe) subcutaneously every 8 weeks.	56-day supply	
Other Medication Name:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: HBsAg: _____ Anti-HBs: _____ Anti-HBc: _____

If applicable, has treatment been initiated? ☐ Yes ☐ No

Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB

If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No

History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

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

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____