DERMATOLOGY REFERRAL FORM A-D

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

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

Phone: _____ Cell Phone: _____ Email Address: _____

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

ICD-10 Diagnosis Code: _____ Diagnosis: _____ Weight: _____

Allergies (please note reaction): _____ ☐ Latex

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

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

Prescription Information

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

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.	2 syringes	
		☐ 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, and 3. ☐ Loading Dose: Inject 300mg (2 injections of 150mg) subcutaneously once weekly at weeks 0, 1, 2, and 3.	☐ 4 pens/ syringes ☐ 8 pens/ syringes	
	☐ 150mg Prefilled Syringe	☐ Maintenance Dose: Starting at week 4, inject 150mg subcutaneously every 4 weeks. ☐ Maintenance Dose: Starting at week 4, inject 300mg (2 injections of 150mg) subcutaneously every 4 weeks.	☐ 1 pen/ syringe ☐ 2 pen/ syringes	
☐ 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.	2 syringes	

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

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

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DERMATOLOGY REFERRAL FORM E-N

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

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

Phone: _____ Cell Phone: _____ Email Address: _____

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

ICD-10 Diagnosis Code: _____ Diagnosis: _____ Weight: _____

Allergies (please note reaction): _____ ☐ Latex

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

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

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Enbrel (etanercept)	☐ 50mg/mL Sureclick Auto-injector ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL Enbrel Mini	☐ Loading Dose: Inject 50mg subcutaneously twice a week (72-96 hours apart) for 3 months.	8 auto-injectors/ syringes	2
		☐ Maintenance Dose: Inject 50mg subcutaneously once a week.	4 auto-injectors/ syringes	
☐ 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.	1 kit	
	☐ 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.	☐ 2 pens/ syringes ☐ 4 pens/ syringes	

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

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

DERMATOLOGY REFERRAL FORM O-R

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____ Weight: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
Comorbidities: (list here or attach a list): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Orencia (abatacept)	☐ 250mg Vial (IV use only)	☐ Loading Dose: Administer _____mg via intravenous infusion at 0, 2 and 4 weeks. ☐ Maintenance Dose: Administer _____mg via intravenous infusion every 4 weeks.		
	☐ 125mg/mL Prefilled Syringe	☐ Inject 125mg subcutaneously once weekly.	4 syringes	
☐ 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 starter pack	
	☐ 30mg Tablet	☐ Maintenance Dose: Take 1 tablet by mouth twice daily.	60 tablets	
		☐ Maintenance Dose (severe renal impairment, CrCL < 30mL/min): Take 1 tablet by mouth once daily.	30 tablets	
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb)	100mg Vial	Loading Dose: Administer _____mg (at 5 mg/kg) intravenously at 0, 2 and 6 weeks.		
		Maintenance Dose: Administer ____ mg (at 5mg/kg) intravenously every ___weeks.		

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

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

DERMATOLOGY REFERRAL FORM S

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____ Weight: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
Comorbidities: (list here or attach a list): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ 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.	4 syringes	
		☐ Maintenance Dose: Inject 210mg (1 syringe) subcutaneously every 2 weeks.	2 syringes	
☐ Simponi (golimumab)	☐ 50mg/0.5mL SmartJect Auto-injector ☐ 50mg/0.5mL Prefilled Syringe	☐ Inject 50mg subcutaneously once a month.	1 auto-injector/ syringe	
☐ Skyrizi™	☐ 75mg/0.83mL Prefilled Syringe	☐ Inject 150mg (two 75mg injections) subcutaneously at week 0, week 4, and every 12 weeks thereafter ☐ Inject 150mg (two 75mg injections) subcutaneously every 12 weeks starting at week 4.	2 syringes	
☐ 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.	1 syringe	
		☐ Maintenance Dose: Inject the contents of 1 prefilled syringe subcutaneously every 12 weeks.	1 syringe	

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

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

DERMATOLOGY REFERRAL FORM T – Z

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____ Weight: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
Comorbidities: (list here or attach a list): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Taltz (ixekizumab)	☐ 80mg/mL Auto-injector ☐ 80mg/mL Prefilled Syringe	☐ Psoriasis: Inject 160mg subcutaneously at week 0, then inject 80mg subcutaneously every other week for 12 weeks. ☐ Psoriatic Arthritis: Inject 160mg subcutaneously on day 1. Then inject 80mg subcutaneously every 4 weeks.	☐ 3 injectors/ syringes ☐ 1 injector/ syringe	
		☐ Maintenance Dose: Inject 80mg subcutaneously every 4 weeks.	1 syringe	
☐ Tremfya (guselkumab)	100mg/mL Prefilled Syringe	☐ Loading Dose: Inject 100mg (1 syringe) subcutaneously at weeks 0 and 4, then every 8 weeks thereafter.	1 syringe	
		☐ Maintenance Dose: Inject 100mg (1 syringe) subcutaneously every 8 weeks.	1 syringe	
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

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____