DERMATOLOGY REFERRAL FORM A-D















PAVILIONS. CARRS |

	9
	ī
_	4
<u>a</u>	(
=	(
	9
8	3
ň	(
	4
	9

		Cell Phone:				
Address:		City:		State:	Zip:	
Current Medication	ons: (list here or attach	Diagnosis:			Latex	
Comorbidities: (iis	st here or attach a list):					
	INSURANCE INFO	DRMATION - FAX COPY OF PATIE	NT'S INSURANCE CARD	- BOTH SID	ES	
MEDICATION	STRENGTH	DIRE	CTIONS		QUANTITY	REFILLS
	Starter Kit 200mg/	Loading Dose: Inject 400mg (2 syring	es) subcutaneously at weeks 0,	2 and 4.	1 kit	

0	on
	ati
Ţ	Ĕ
esc	o
ב	Ιυ

	mL Prefilled Syringe		ataneously at weeks 0, 2 and 4.	(6 syringes)
Cimzia (certolizumab)			subcutaneously every 4 weeks.	2 syringes
Prefilled Syringe		Maintenance Dose: Inject 200mg (1 syringe) su	ibcutaneously every 2 weeks.	2 symiges
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.	
(secukinumab) [] 150mg Prefilled Syringe	Maintenance Dose: Starting at week 4, inject 15 4 weeks. Maintenance Dose: Starting at week 4, inject 300m subcutaneously every 4 weeks.		l pen/syringe 2 pen/syringes	
Dupixent (dupilumab)	300mg/2mL Prefilled Syringe	Loading Dose: Inject 600mg (given as two 300 subcutaneously one time.	mg injections in different sites)	2 syringes
(dupilumab) Preililed Syninge		Maintenance Dose: Inject 300mg subcutaneou	Maintenance Dose: Inject 300mg subcutaneoulsy every other week.	
Treatment History: New to Therapy Hepatitis B Screening Results: HBsAg: Anti-HBs: Anti-HBc: If applicable, has treatment been initiated? Yes No Tuberculosis Assessment Date: Negative If history of active or latent TB: Adequate treatment is confirmed: Yes No				
	Bowel Disease: Ye			
State License #: _ Additional Contac	t Person Name:	DEA #:		
Group or Hospital:			Phone:	
Fax: Address:		Email Address: City:	State:	7in:
	Fax:Email Address:			
<u> </u>	Product Subs		ised 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.				
Chira to Dottiont	Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy Date Medication Needed:			

Prescriber

Confidentiality Warning: The information contained in this facsimile message is privileged and confidential information intended only for the review and use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication of the information contained herein is strictly prohibited. If you have received this communication in error, please immediately notify sender by telephone, and destroy the original documents.

It's as simple as caring.

DERMATOLOGY REFERRAL FORM E-N













PAVILIONS CARRS () Randalls

	C
	- 1
_	-
1)	C
	_
	_
-	
•	_
•	C
	-
	\sim
	_

F Patient Name: . DOB: Cell Phone: _ Email Address: Phone: City: __ Address:_ Zip: ICD-10 Diagnosis Code: Weight: Diagnosis: _ Allergies (please note reaction): _ 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 **MEDICATION STRENGTH DIRECTIONS** QUANTITY **REFILLS** 8 auto-50mg/mL Sureclick Loading Dose: Inject 50mg subcutaneously twice a week injectors/ 2 Auto-injector (72-96 hours apart) for 3 months. syringes Enbrel 50mg/mL Prefilled (etanercept) 4 auto-Syringe Maintenance Dose: Inject 50mg subcutaneously once a week. injectors/] 50mg/mL Enbrel Mini syringes

Prescription	Information
_	

	Citrate-free Psoriasis Starter Kit (3 pens) Psoriasis Starter Kit (4 pens)	to < 60 kg) Loading Dos	ult) or Hidradenitis Suppu e: Inject 80mg subcutane ny 22 and every OTHER we	urativa (12 years and older, 30 kg eously on day 1, then 40mg on eek thereafter.	1 kit
Humira	Citrate-free Hidradenitis Suppurativa Starter Kit (3 pens)	Iniect 160ma (two 80ma	a pens) subcutaneously d	nd older, ≥ 60 kg) Loading Dose: on day 1, then 80mg (one 80mg ay 29 and once a week thereafter.	1 kit
(adalimumab)	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	30 kg to < 60 kg) Maii then every OTHER week	ntenance Dose: Inject 401 thereafter. ativa (adult or 12 years ar	urativa (12 years and older, mg subcutaneously on day 22 nd older, ≥ 60 kg) Maintenance en once a week thereafter.	2 pens/ syringes 4 pens/ syringes
Hepatitis B Screenino If applicable, has Tuberculosis Assessi If history of active or	treatment been initiated:	Anti-H	Bs:	Anti-HBc: History of act nt is confirmed: Y	
Additional Contact F Group or Hospital:	reison name.			Phone:	
	<u>:</u>			State:	Zip:
The prescriber is to con	Product Substitution	n Permitted ription requirements such	Dispensed	d as Written pecific prescription form, fax langua	Date ge, etc. Non-
	Ship to Prescriber/C	_ '	·	Pharmacy Date Medication N	

Prescriber

Information Delivery

ntiality Warning. The information contained in this facsimile message is privileged and confidential information intended only for the review and use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication of the information contained herein is strictly prohibited. If you have received this communication in error, please immediately notify sender by telephone, and destroy the original documents.

It's as simple as caring.

DERMATOLOGY REFERRAL FORM O-R











PAVILIONS CARRS () Randalls.

	_
	\circ
	.=
	7
$\overline{}$	\Box
w	~
=	⊱
=	- :-
0	=
n	O
	4
	_

Prescription

Prescriber

Delivery

Patient Name:		DOB:	Sex:M	F
Phone:	C	rell Phone: Email Address:	7:	
Address:	l	City: State: Diagnosis:	Zip:	
Allergies (plages pe	te reaction):	Diagnosis:	. weight:	7
Current Medication	e: (list boro or attach a mo	edication list):		⊥Latex
		edication list)		
COTTOTOTOTOTOTO. (IISC)	icic of attacit a list).			
	INSURANCE INFORM	IATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDI	ES	
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
MESICATION		Loading Dose: Administermg via intravenous infusion at 0, 2 and 4 weeks.	QUALITY	REI IEEO
	250mg Vial			
Orencia (abatacept)	(IV use only)	Maintenance Dose: Administermg via intravenous infusion every 4 weeks.		
(арагасерг)	125mg/mL Prefilled Syringe	☐ Inject 125mg subcutaneously once weekly.	4 syringes	
	, ,	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		
	14-day Starter Pack	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.	1 starter	
Ottorio	28-day Starter Pack	The office Board (common discount and Complete South and Complete Sout	pack	
Utezla (apremilast)		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		
(1)		days 4 and 5; then take 30mg in the morning on day 6 and thereafter.		
		Maintenance Dose: Take 1 tablet by mouth twice daily.	60 tablets	
30mg Tablet		Maintenance Dose (severe renal impairment, CrCL < 30mL/min): Take 1 tablet by mouth once daily.		
Remicade		Loading Dose: Administermg (at 5 mg/kg) intravenously at 0, 2 and 6 weeks.		
(infliximab)		The fact of the property at 0,2 and 0 weeks.		
- India atua	100mg Vial			
☐Inflectra (infliximab-dyyb)		Maintenance Dose: Administermg (at 5mg/kg) intravenously everyweeks.		
Treatment Hi	story: \square New to 1	herapy		
Hepatitis B Screening	g Results: HBsAg:	Anti-HBs: Anti-HBc:		
	treatment been initiated?			
				_
I uberculosis Assessi If history of active or	ment Date:	Negative Active TB Latent TB History of active Adequate treatment is confirmed: Ye	e or latent 11	В
•			es 🗀 NO	
History of Irritable Bo	wel Disease: Yes	No		
Prescriber Name:				
State License #:		Dea #: NPI:		
Additional Contact F	erson Name:	Phone:		
Fax:		Email Address: Trione		
Address: City: Zip:				
Prescriber Signature	<u> </u>			
-	Product Substitutio	n Permitted Dispensed as Written	Do	ite
		ription requirements such as e-prescribing, state specific prescription form, fax languag	je, etc. Non-	
compliance with state	specific requirements could r	esult in outreach to the prescriber.		
Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy Date Medication Needed:				
Confidentiality Warnin	ar The information contained	d in this facsimile message is privileged and confidential information intended only f	or the review	and

use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication of the information contained herein is strictly prohibited. If you have received this communication

It's as simple as caring.

in error, please immediately notify sender by telephone, and destroy the original documents.

DERMATOLOGY REFERRAL FORM S











PAVILIONS CARRS () Randalls

	ō
_	
	-
ā	O
=	\subseteq
-	
0	_
ň	0
	4

		Cell Phone:			
			St		
ICD-10 Diagnosis C	Code:	Diagnosis:		Weight:	
Current Medication	ns: (list here or attach a m	Diagnosis:edication list):			Latex
	INSURANCE INFORM	MATION - FAX COPY OF PATIENT	S INSURANCE CARD - B	OTH SIDES	
MEDICATION	STRENGTH	DIRECT	IONS	QUANTITY	REFILLS

	_
)	ō
3	Ξ
_	2
5	Ξ.
Ď	ō
ע	Ţ

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				
(Broddidirids)		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	Loading Dose: Inject the contents of 1 prefilled syringe subcutaneously on Day 1 and then repeat on Day 29.	1 syringe				
	90mg/mL Prefilled Syringe	Maintenance Dose: Inject the contents of 1 prefilled syringe subcutaneously every 12 weeks.	1 syringe				
Treatment H	•	Therapy Continuation of Therapy					
Hepatitis B Screenir	•	Anti-HBs: Anti-HBc:					
	s treatment been initiated?						
Tuberculosis Assessment Date: Negative Active TB Latent TB History of active or latent TB Adequate treatment is confirmed: Yes No							
History of Irritable B	owel Disease: Yes	□No					
Prescriber Name: _							
State License #: DEA #: NPI: NPI: Additional Contact Person Name:							
Group or Hospital:		Phone:					
Group or Hospital:							
		· /					
Prescriber Signatur	e:						
Product Substitution Permitted Dispensed as Written Date							
		ription requirements such as e-prescribing, state specific prescription form, fax languresult in outreach to the prescriber.	uage, etc. Non-				
Ship to Patient	Ship to Prescriber/Cl	inic Pick up at Albertsons Companies Pharmacy Date Medication	ı Needed:				

Prescriber

Confidentiality Warning: The information contained in this facsimile message is privileged and confidential information intended only for the review and use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication of the information contained herein is strictly prohibited. If you have received this communication in error, please immediately notify sender by telephone, and destroy the original documents.

It's as simple as caring.

DERMATOLOGY REFERRAL FORM T - Z













PAVILIONS CARRS () Randalls

	- (
	ī
_	- 4
o	(
$\underline{\underline{}}$	-
	- (
0	3
~	(
_	4
	9

Prescriber

Patient Name: _		2 2	DOB: Email Address: State: _	Sex:	
Pnone: Address:		City	Email Address: :: State:	Zip:	
ICD-10 Diagnosis	Code:	Diagnosis:		Weight:	
Allergies (please r Current Medication	note reaction): ons: (list here or attach a m	edication list):			Latex
	INSURANCE INFORM	MATION - FAX COPY OF PAT	TENT'S INSURANCE CARD - BOTH S	SIDES	
MEDICATION	STRENGTH		DIRECTIONS	QUANTITY	REFILLS
□ Taltz (ixekizumab)	80mg/mL Auto-injector 80mg/mL Prefilled Syringe	Psoriasis: Inject 160mg subcuta subcutaneously every other we	neously at week 0, then inject 80mg sek for 12 weeks.	3 injectors/	
		Psoriatic Arthritis: Inject 160mg s subcutaneously every 4 weeks.	ubcutaneously on day 1. Then inject 80mg	l injector/ syringe	
		Maintenance Dose: Inject 80mg	g subcutaneously every 4 weeks.	1 syringe	
Tremfya (guselkumab)	100mg/mL Prefilled Syringe	Loading Dose: Inject 100mg (1 s then every 8 weeks thereafter.	syringe) subcutaneously at weeks 0 and 4,	1 syringe	
		Maintenance Dose: Inject 100m	ng (1 syringe) subcutaneously every 8 weeks.	. 1 syringe	
Other Medication Name:					
Hepatitis B Screen	History: New to ing Results: HBsAg:	Anti-HBs:	nuation of Therapy Anti-HBc:		
If history of active	ssment Date: [or latent TB: Bowel Disease: Yes	Adequ	Latent TB History of a late treatment is confirmed:	active or latent TE Yes No	3
,					
State License #: _	t Person Name:	DEA #:	NPI:		
Group or Hospital:		Email Address:	Phone:		
Address:		Email Address:	City: State:	Zip:	
Prescriber Signatu	re:				
			Dispensed as Written cribing, state specific prescription form, fax lanç	Dat guage, etc. Non-	te
Ship to Patient	Ship to Prescriber/C	linic Pick up at Albertsons	Companies Pharmacy Date Medicatio	on Needed:	
use of the individual	or entity to which it is addres	sed. If the reader of this message is	eged and confidential information intended o not the intended recipient, you are hereby no nined herein is strictly prohibited. If you have i	otified that any disc	closure,

It's as simple as caring.

in error, please immediately notify sender by telephone, and destroy the original documents.