RICHMOND PHARMACY
Specialty Script

355 Bard Ave • Staten Island, NY 10310 • www.RichmondSpecialty.com

PHONE: 718-818-2178 • FAX: 718-818-2179

Date: ____/____/____ Needs by Date: _____

Language: _____ ☐ Nursing Instruction Required

Ship to: ☐ Patient ☐ MD Office

DERMATOLOGY REFERRAL FORM

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ____/____/____ Gender: ☐F ☐M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

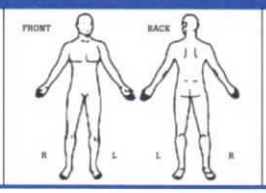
Diagnosis (ICD-10)

- ☐ L40.50 Arthropathic Psoriasis (unspecified)
- ☐ L40.51 Distal Interphalangeal Psoriatic Arthropathy
- ☐ L40.52 Psoriatic Arthritis Mutilans
- ☐ L40.53 Psoriatic Spondylitis
- ☐ L40.59 Other Psoriatic Athropathy
- ☐ L40.0 Psoriasis Vulgaris
- ☐ L40.8 Other Psoriasis
- ☐ L40.9 Psoriasis (unspecified)
- ☐ L73.2 HidradenitisSuppurativa(HS)

❑ Other ICD-10 _____

Date of Diagnosis _____

Years w/Disease _____



BSA % Affected by Psoriasis _____

Medical Assessment (Within Last 12 Months)

Psoriasis Severity: ❑ Moderate ❑ Moderate to Severe ❑ Severe

Psoriasis Type: ❑ Plaque ❑ Other _____

❑ Specialty Pharmacy to Coordinate Injection Training/ Home Health Nurse as Needed ❑ YES ❑ NO

Has patient been diagnosed with Lymphoma: ❑ YES ❑ NO

Does patient have a latex allergy: ❑ YES ❑ NO

Is patient's platelet count > 52,000 cells/uL ❑ YES ❑ NO

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ **Cosentyx** *	☐ 300mg ☐ 150mg	☐ **Starter Dose:** Inject SQ at weeks 0, 1, 2, 3 and 4 ☐ **Maintenance Dose: Inject SQ every 4 weeks** ☐ **Other:** _____		0
☐ **Dupixent** *	☐ 300mg/2mL Prefilled Syringe	☐ **Starter Dose:** 600mg SC divided in 2 differnent injection sites ☐ **Maintenance Dose:** 300mg SC every other week	2 2	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 three months)* ☐ **Maintenance Dose:** Inject 50mg SC ONCE a week ☐ **Other:** _____		
☐ **Humira** * ☐ Injectiontraining fromMyHumira *(patient must sign below)*	☐ 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
☐ **Otelza** *	☐ Tiration Starter Pack Rx ☐ 30mg Tablet	☐ Use as directed by the manufacturer ☐ **Other:** _____	1 Pack	0
☐ **Siliq** *	☐ 210mg/1.5mL Prefilled Syringe	☐ **Starter Dose:** ☐ 210mg SC on weeks 0, 1, 2 ☐ **Maintenance Dose:** ☐ 210mg SC every 2 weeks		0
☐ **Simponi** ™	☐ 50mg/0.5mL Smartjet™ Autoinjector ☐ 50mg/0.5mL Prefilled Syringe	☐ Psoriatic Arthritis Dose: Inject 50mg (0.5mL) subcutaneously once a month ☐ **Other:** _____		
☐ **Simponi Aria** *		☐ 2mg/kg IV at weeks 0 and 4, then q 8 weeks ☐ **Other:** _____		
☐ **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) *29 days after starter dose and then every 12 weeks* ☐ Inject 90mg SC (patient >100 kg) *29 days after starter dose and then every 12 weeks* **Other:**	☐ Initial Dose: 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	☐ Inject 100mg SC at week 0 and 4, then Q8W		
☐ **Valchlor** ™	☐ 0.016% gel	Apply a thin film once daily to the affected aread of the body. Directions, if different from above:		

Physician Signature: _____ Date: _____

For additional information please visit our website **www.RichmondSpecialty.com**

ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • **(718) 818-2178**