AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: ________________ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

DERMATOLOGY REFERRAL FORM (A - G)

PATIENT INFORMATION

Patient Name: | DOB: | Sex: ☐ M ☐ F ☐ Other: | Weight: | ☐ lbs. ☐ kg.
SSN: | Phone: | Allergies:
Address: | City: | State: | Zip:
Emergency Contact: | Phone: | ☐ **Additional Information Attached**

PRESCRIBER INFORMATION

Prescriber: | NPI: | DEA: | State Lic:
Supervising Physician: | Practice Name:
Address: | City: | State: | Zip:
Phone: | Fax: | Key Office Contact: | Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ L28.1 Prurigo nodularis ☐ L40.0 Psoriasis ☐ L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis ☐ L40.59 ☐ L50.1 Chronic Idiopathic Urticaria ☐ L73.2 Hidradenitis Suppurativa ☐ Other: ________

- Location: ☐ Hands ☐ Feet ☐ Face ☐ Scalp ☐ Groin ☐ Nails ☐ Others: ________
- Severity: ☐ Mild (up to 3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (greater than 10% BSA), BSA ________%

If treated previously for this condition, please indicate which drugs have been tried and failed: ________

Date range of previous therapy: ________

- Is patient currently on therapy? ☐ Yes ☐ No Type / medication(s): ________
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No, if yes, how long should patient wait before starting the new medication? ________
- Has patient received a PPD (tuberculosis) Skin Test? ☐ Yes ☐ No Results: ________

Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

☐ **STC Standard Protocol** will include the following: (1) dispensing ordered med / dose, (2) diluent to mix and / or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg / mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Bimzelx® ☐ **160 mg / mL Pen** *OR* ☐ **160 mg / mL Syringe**
☐ 320 mg (given as two 160 mg injections) SQ every 4 weeks for the first 16 weeks — QTY: 2 | Refills: 4
☐ 320 mg (given as two 160 mg injections) SQ every 8 weeks — QTY: 2 | Refills:

Cibinqo® ☐ **50 mg Tablet** ☐ **100 mg Tablet** ☐ **200 mg Tablet**
☐ 1 tablet PO once daily ☐ Other: ________ — QTY: 1 Month | Refills:

Cimzia® ☐ 400 mg / mL SQ every 2 weeks
☐ 400 mg SQ at Weeks 0, 2, 4, then 200 mg every other week thereafter (patient <=90 kg) — QTY: 1 Month | Refills:

Cosentyx® ☐ **150 mg / mL Sensoready® Pen** ☐ **150 mg / mL Prefilled Syringe** ☐ **150 mg Vial of Lyophilized Powder** ☐ **300 mg UnoReady Pen**
**Sensoready® Pen will be dispensed if no preference indicated*
☐ *Starter Dose:* 300 mg SQ initially (Weeks 0, 1, 2, 3 and 4) then 300 mg SQ every 4 weeks thereafter (Week 4) ☐ Starter Dose not needed — QTY: 5 Weeks | Refills: 0
☐ *Maintenance Dose:* 300 mg SQ every 4 weeks — QTY: 1 Month | Refills:
☐ Other: ________ — QTY: 1 Month | Refills:

Dupixent® (Dupilumab) ☐ **200 mg Pen Autoinjector** ☐ **200 mg Prefilled Syringe** ☐ **300 mg Pen Autoinjector** ☐ **300 mg Prefilled Syringe**
**Pen will be dispensed if no preference indicated for adult dosing. Prefilled Syringe may be used in ages ≥ 6 months. Prefilled Pen is only for use in ages ≥ 2 years.*

Adults: ☐ *Starter Dose:* Inj. 600 mg SQ on Day 1, then 300 mg SQ every 2 weeks starting on Day 15 ☐ Starter Dose not needed — QTY: QS for Starter | Refills: 0
☐ *Maintenance Dose:* Inj. 300 mg (1 Syringe) SQ every 2 Weeks — QTY: 1 Month | Refills:

Infants & Children: ≥ 6 mo - < 6 yrs: Initial loading dose not necessary in pediatric patients < 6 yrs.
☐ 5 to < 15 kg: Dupixent 200 mg SQ every 4 weeks ☐ 15 to < 30 kg: Dupixent 300 mg SQ every 4 weeks — QTY: 1 Box: 2 Pens / Syringes | Refills:

Children & Adolescents: ≥ 6 years - ≤ 17 years:
☐ 15 to < 30 kg: *Initial:* 600 mg SQ once (administered as two 300 mg injections), followed by a maintenance dose of 300 mg every 4 weeks — QTY: 1 Box: 2 Pens / Syringes | Refills: 0
☐ 15 to < 30 kg: *Maintenance:* 300 mg SQ every 4 weeks — QTY: 1 Box: 2 Pens / Syringes | Refills:
☐ 30 to < 60 kg: *Initial:* 400 mg SQ once (administered as two 200 mg injections), followed by a maintenance dose of 200 mg every other week — QTY: 1 Box: 2 Pens / Syringes | Refills: 0
☐ 30 to < 60 kg: *Maintenance:* 200 mg SQ every other week — QTY: 1 Box: 2 Pens / Syringes | Refills:
☐ ≥ 60 kg: *Initial:* 600 mg SQ once (administered as two 300 mg injections), followed by a maintenance dose of 300 mg every other week — QTY: 1 Box: 2 Pens / Syringes | Refills: 0
☐ ≥ 60 kg: *Maintenance:* 300 mg SQ every other week — QTY: 1 Box: 2 Pens / Syringes | Refills:

Enbrel® ☐ **50 mg / mL SureClick (Autoinjector)** ☐ **50 mg Prefilled Syringe** ☐ **Mini 50 mg Cartridge** **SureClick will be dispensed if no preference indicated* ☐ **Enroll in Enliven® Program**
☐ *Starter Dose:* 50 mg SQ twice weekly (72 - 96 hours apart) for 3 months ☐ Starter Dose not needed — QTY: 1 Month | Refills: 2
☐ *Maintenance Dose:* 50 mg SQ weekly ☐ Other: ________ — QTY: 1 Month | Refills:

Enbrel® ☐ **25 mg / 0.5 mL Prefilled Syringe** ☐ **25 mg Single-Use Vial** **Prefilled Syringe will be dispensed if no preference indicated*
☐ 25 mg SQ twice weekly (72 - 96 hours apart) ☐ Other: ________ — QTY: 1 Month | Refills:

Erivedge® ☐ **150 mg Capsules** Take 1 capsule orally once daily — QTY: 28 Capsules | Refills:

Prescriber's Signature: ________ ☐ DAW (Dispense as Written) **Date:** ________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: ________________ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

DERMATOLOGY REFERRAL FORM (H - R)

PATIENT INFORMATION

Patient Name: | DOB: | Sex: ☐ M ☐ F ☐ Other: | Weight: | ☐ lbs. ☐ kg.
SSN: | Phone: | Allergies:
Address: | City: | State: | Zip:
Emergency Contact: | Phone: | ☐ **Additional Information Attached**

PRESCRIBER INFORMATION

Prescriber: | NPI: | DEA: | State Lic:
Supervising Physician: | Practice Name:
Address: | City: | State: | Zip:
Phone: | Fax: | Key Office Contact: | Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ L28.1 Prurigo nodularis ☐ L40.0 Psoriasis ☐ L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis ☐ L40.59 ☐ L50.1 Chronic Idiopathic Urticaria
☐ L73.2 Hidradenitis Suppurativa ☐ Other: ____________

- Location: ☐ Hands ☐ Feet ☐ Face ☐ Scalp ☐ Groin ☐ Nails ☐ Others: ____________
- Severity: ☐ Mild (up to 3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (greater than 10% BSA), BSA ____________%

If treated previously for this condition, please indicate which drugs have been tried and failed: ____________
Date range of previous therapy: ____________

- Is patient currently on therapy? ☐ Yes ☐ No Type / medication(s): ____________
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No, if yes, how long should patient wait before starting the new medication? ____________
- Has patient received a PPD (tuberculosis) Skin Test? ☐ Yes ☐ No Results: ____________

Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

☐ **STC Standard Protocol** will include the following: (1) dispensing ordered med / dose, (2) diluent to mix and / or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg / mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Humira® ☐ **CF Pen Psoriasis Starter Kit** *NDC: 0074-1539-03* ☐ **CF 40 mg / 0.4 mL Prefilled Syringe** *NDC: 0074-0243-02* — ☐ **Enroll in Humira Complete Program**
**Pen Starter Kit will be dispensed if no preference indicated*

☐ *Starter Dose for Psoriasis:*
- ☐ One 80 mg SQ inj. **Day 1**, one 40 mg SQ inj. **Day 8**, one 40 mg SQ inj. **Day 22** *(OR)* — QTY: 3 Pens | Refills: 0
- ☐ Two 40 mg SQ inj. **Day 1**, one 40 mg SQ inj. **Day 8**, one 40 mg SQ inj. **Day 22** — QTY: 4 Syringes | Refills: 0

☐ Starter Dose not needed

Humira® ☐ **CF 40 mg / 0.4 mL Pen** *NDC: 0074-0554-02* ☐ **CF 40 mg / 0.4 mL Syringe** *NDC: 0074-0243-02*
**Pen will be dispensed if no preference indicated*

☐ *Maintenance Dose for Psoriasis:* 40 mg SQ once every other week — QTY: 1 Month | Refills:

Humira® ☐ **Starter Pkg CF 80 mg / 0.8 mL Pen** *NDC: 0074-0124-03* ☐ **CF 40 mg / 0.4 mL Prefilled Syringe** *NDC: 0074-0243-02*
**Pen will be dispensed if no preference indicated*

☐ *Starter Dose for Hidradenitis Suppurativa:*
- ☐ Inj. 160 mg SQ Day 1, then 80 mg SQ Day 15 *(OR)* — QTY: 1 Month | Refills: 0
- ☐ Inj. 80 mg SQ Day 1, and 80 mg SQ Day 2, then 80 mg SQ Day 15 — QTY: 1 Month | Refills: 0

☐ Starter Dose not needed

Humira® ☐ **CF 40 mg / 0.4 mL Pen** *NDC: 0074-0554-02* ☐ **CF 40 mg / 0.4 mL Syringe** *NDC: 0074-0243-02*
**Pen will be dispensed if no preference indicated*

☐ *Maintenance Dose for Hidradenitis Suppurativa:* 40 mg SQ Day 29 and every week thereafter — QTY: 1 Month | Refills:
☐ Other: ____________ — QTY: ______ | Refills:

Ilumya® ☐ **100 mg / mL Prefilled Syringes**
- ☐ *Starter Dose:* 100 mg SQ on Week 0 and Week 4 — QTY: 1 Month (1 PFS) | Refills: 0
- ☐ *Maintenance Dose:* 100 mg SQ every 12 weeks (starting at Week 4) — QTY: 1 Syringe | Refills:

☐ Starter Dose not needed

Kevzara® *(Sarilumab)* ☐ **200 mg / 1.14 mL Pen Autoinjector** ☐ **200 mg / 1.14 mL Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
☐ 200 mg subcutaneously every 2 Weeks — QTY: 1 Box (2) | Refills:

Odomzo® ☐ **200 mg Capsule PO Once Daily** — QTY: 30 CAPS | Refills:

Otezla® Tablets
- ☐ *Titration Dose:* **DAY 1**: 10 mg in morning; **DAY 2:** 10 mg in morning & 10 mg in evening; **DAY 3:** 10 mg in morning & 20 mg in evening; **DAY 4**: 20 mg in morning & 20 mg in evening; **DAY 5:** 20 mg in morning & 30 mg in evening; **DAY 6 & thereafter:** 30 mg twice daily — QTY: 1 Month | Refills: 0
- ☐ *Maintenance Dose:* 30 mg twice daily — QTY: 60 TABS (30 mg) | Refills:
- ☐ Other: ____________ — QTY: ______ | Refills:

☐ **Remicade®** 100 mg Vial ☐ **Inflectra®** 100 mg Powder Vial ☐ **Renflexis®** 100 mg Powder Vial ☐ **Avsola®** 100 mg Powder Vial — ☐ **Enroll in AccessOneSM Program**
- ☐ MD's Office Infusion ☐ Home Infusion Supplies Required
- ☐ *Starter Dose:* __________ mg IV on Week 0, Week 2, Week 6, then — QTY: QS 3 Infusions | Refills: 0
- ☐ *Maintenance Dose:* __________ mg IV every __________ weeks — QTY: QS 1 Infusion | Refills:

☐ Starter Dose not needed

Rinvoq® ☐ **15 mg Tablet** ☐ **30 mg Tablet** Take 1 tablet PO once daily — QTY: 1 Month | Refills:

Prescriber's Signature: ______________________ ☐ DAW (Dispense as Written) **Date:** __________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: ________________ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

DERMATOLOGY REFERRAL FORM (S - Z)

PATIENT INFORMATION

Patient Name: | DOB: | Sex: ☐ M ☐ F ☐ Other: | Weight: | ☐ lbs. ☐ kg.
SSN: | Phone: | Allergies:
Address: | City: | State: | Zip:
Emergency Contact: | Phone: | ☐ **Additional Information Attached**

PRESCRIBER INFORMATION

Prescriber: | NPI: | DEA: | State Lic:
Supervising Physician: | Practice Name:
Address: | City: | State: | Zip:
Phone: | Fax: | Key Office Contact: | Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ L28.1 Prurigo nodularis ☐ L40.0 Psoriasis ☐ L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis ☐ L40.59 ☐ L50.1 Chronic Idiopathic Urticaria ☐ L73.2 Hidradenitis Suppurativa ☐ Other: ______

- Location: ☐ Hands ☐ Feet ☐ Face ☐ Scalp ☐ Groin ☐ Nails ☐ Others: ______
- Severity: ☐ Mild (up to 3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (greater than 10% BSA), BSA ______%

If treated previously for this condition, please indicate which drugs have been tried and failed: ______

Date range of previous therapy: ______

- Is patient currently on therapy? ☐ Yes ☐ No Type / medication(s): ______
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No, if yes, how long should patient wait before starting the new medication? ______
- Has patient received a PPD (tuberculosis) Skin Test? ☐ Yes ☐ No Results: ______

Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

☐ **STC Standard Protocol** will include the following: (1) dispensing ordered med / dose, (2) diluent to mix and / or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg / mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

Siliq® ☐ **210 mg / 1.5 mL Prefilled Syringe (2 pack)** ☐ Starter Dose not needed ☐ **Enroll in REMS Program**
- ☐ *Starter Dose for Plaque Psoriasis:* 210 mg SQ at Weeks 0, 1 and 2, followed by maintenance dose — QTY: 1 Box (2 PFS) | Refills: 0
- ☐ *Maintenance Dose for Plaque Psoriasis:* 210 mg SQ once every two weeks (Starting at Week 2) — QTY: 1 Box (2 PFS) | Refills: ______

Simponi® ☐ **Aria 50 mg / 4 mL** Patient Weight (kg): ______ ☐ Starter Dose not needed ☐ **Enroll in SimponiOne® Program**
- ☐ *Starter Dose:* 2 mg / kg IV at Weeks 0 and 4 — QTY: 1 Month | Refills: 0
- ☐ *Maintenance Dose:* 2 mg / kg IV every 8 weeks — QTY: QS for 8 Weeks | Refills: ______

Simponi® ☐ **SmartJect 50 mg / 0.5 mL** ☐ **50 mg / 0.5 mL Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
- ☐ 50 mg SQ every month — QTY: 1 Month | Refills: ______
- ☐ Other: ______ — QTY: ______ | Refills: ______

Skyrizi® ☐ **150 mg / mL Pen Autoinjector** ☐ **150 mg / ml Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
- ☐ *Starter Dose:* 150 mg SQ at Week 0 and 4 ☐ Starter Dose not needed — QTY: 1 | Refills: 1
- ☐ *Maintenance Dose:* 150 mg SQ every 12 weeks — QTY: 1 | Refills: ______

Sotyku® ☐ 6 mg PO once daily — QTY: ______ | Refills: ______

Stelara® ☐ **Prefilled Syringe** ☐ **Vial** ☐ MD's Office Infusion ☐ Home Infusion Supplies Required **Prefilled Syringe will be dispensed if preference is not indicated* ☐ **Enroll in Janssen CarePath Program**
- ☐ *≤ 100 kg Starter Dose:* 45 mg SQ initially (Week 0), then 45 mg SQ after 4 weeks of initial dose (Week 4) — QTY: 1 x 45 mg | Refills: 1
- ☐ *≤ 100 kg Maintenance Dose:* 45 mg SQ every 12 weeks ☐ Other: ______ — QTY: 1 x 45 mg | Refills: ______
- ☐ *> 100 kg Starter Dose:* 90 mg SQ initially (Week 0), then 90 mg SQ after 4 weeks of initial dose (Week 4) — QTY: 1 x 90 mg | Refills: 1
- ☐ *> 100 kg Maintenance Dose:* 90 mg SQ every 12 weeks ☐ Other: ______ — QTY: 1 x 90 mg | Refills: ______

Taltz® ☐ **80 mg / mL Autoinjector** ☐ **80 mg / mL Prefilled Syringe** **Pen will be dispensed if no preference is indicated* ☐ Starter Dose not needed
- ☐ *Starter Dose for Plaque Psoriasis:* 160 mg (two 80 mg inj.) at Week 0, then 80 mg at Week 2, 4, 6, 8, 10, 12 — QTY: 8 | Refills: 0
- ☐ *Maintenance Dose for Plaque Psoriasis:* 80 mg every 4 weeks — QTY: 1 | Refills: ______
- ☐ *Starter Dose for Psoriatic Arthritis:* 160 mg (two 80 mg inj.) at Week 0 — QTY: 2 | Refills: 0
- ☐ *Maintenance Dose for Psoriatic Arthritis:* 80 mg every 4 weeks — QTY: 1 | Refills: ______
- ☐ Other: ______ — QTY: ______ | Refills: ______

Tremfya® ☐ **100 mg / mL Pen Autoinjector** ☐ **100 mg / ml Prefilled Syringe** **Pens will be dispensed if no preference is indicated*
- ☐ *Starter Dose:* 100 mg SQ at Week 0, 4, and every 8 weeks thereafter ☐ Starter Dose not needed — QTY: 1 | Refills: 0
- ☐ *Maintenance Dose:* 100 mg SQ every 8 weeks (starting at Week 4) — QTY: 1 | Refills: ______

Xeljanz® ☐ **5 mg Tablet** ☐ **10 mg Tablet:** 1 tablet PO twice daily — QTY: 1 Month | Refills: ______
☐ **11 mg ER Tablet:** 1 tablet PO daily — QTY: 1 Month | Refills: ______

Xolair® ☐ **150 mg Prefilled Syringe** ☐ **150 mg Vial**
☐ 150 mg SQ every 4 weeks ☐ 300 mg SQ every 4 weeks — QTY: 28 Day Supply | Refills: ______

Prescriber's Signature: ______________ ☐ DAW (Dispense as Written) **Date:** ______

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.