DERMATOLOGY REFERRAL FORM

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN:_____ Group: _____

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis _____ **Date of Diagnosis** (or years with disease) _____ **Allergies:** _____

Previously for the condition? ☐ Yes ☐ No If yes, medication/therapy failed (length) _____

Has patient received PPD (tuberculosis) Skin Test? ☐ Yes ☐ No **Does patient have a latex allergy?** ☐ Yes ☐ No

Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No **BSA** _____ % affected by Psoriasis

Enbrel®

☐ 50mg/ml Prefilled Syringe
☐ 50mg/ml SureClick Autoinjector
☐ 25mg/0.5ml Prefilled Syringe

SIG: ☐ **Induction:** Inject 50mg SC twice a week (72-96 hrs apart for 3 months).
☐ **Maintenance:** Inject 50mg SC once a week.
QTY: _____ Refill: _____

Cosentyx®

☐ 300mg ☐ 150mg
SIG: ☐ **Initial:** Inject SC weeks 0, 1, 2, 3, and 4
☐ **Maintenance:** Inject SC every 4 weeks
QTY: _____ Refill: _____

Dupixent®

☐ Two (2) Pens (600mg) Initial Dose, then One (1) Pen (300mg) every other week
☐ One (1) Pen (300mg) every other week
QTY: _____ Refill: _____

Otezla®

SIG: ☐ 28 day starter pack ☐ 30mg 2 x daily
QTY: _____ Refill: _____

Targretin® Capsules

☐ 75mg **SIG:** _____
QTY: _____ Refill: _____

Humira®

☐ 20mg/0.4ml Prefilled Syringe (2 doses)
☐ 40mg/0.8ml Pen (2 doses)
☐ 40mg/0.8ml Prefilled Syringe (2 doses)
☐ 40mg Kit 4 x 0.8ml
☐ 40mg Start Kit 6 x 0.3ml

SIG: ☐ **Initial Dose:** Inject 80mg SC on Day 1.
☐ **Maintenance:** Inject 40mg SC every other week (starting 1 week after initial)
☐ **Other** _____
QTY: ☐ Initial Dose 1; Other: ____ Refill: ____
☐ Injection training required from My Humira

Sivextro®

☐ 200mg **SIG:** Take once daily for 6 days
QTY: _____ Refill: _____

Targretin® Gel

☐ 1% Gel **SIG:** Apply every other day for 1 week, then at weekly intervals: increase to once daily, twice daily, three times daily, and finally four times daily.
QTY: _____ Refill: _____

Stelara®

☐ 45mg/0.5ml Prefilled Syringe
☐ 90mg/1.0ml Prefilled Syringe

SIG: Starter Dose: ☐ Inject 45mg SC (patient < 100kg) at Day 1. ☐ Inject 90mg SC (patient < 100kg) at Day 1.
Maintenance Dose: ☐ Inject 45mg SC (patient < 100kg) 28 days after starter dose and then every 12 weeks. ☐ Inject 90mg SC (patient < 100kg) 28 days after starter dose and then every 12 weeks.
☐ **Other** _____
QTY: ☐ Initial Dose 1; Other: ____ Refill: ____

Oxsoralen-Ultra®

☐ 10mg **SIG:** _____
QTY: _____ Refill: _____

Zolinza®

☐ 400mg **SIG:** ☐ 400mg once daily
☐ Other: _____
QTY: Refill:

Zyvox®

☐ 600mg **SIG:** Twice daily for _____ days
QTY: Refill:

Other/Notes:_____
_____

Prescriber Signature: _____ **DAW (Dispense as Written)** **Date:** _____

If Century Specialty Script is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353