Faxed or E-scribed Prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Access Specialty Pharmacy

Dermatology Prescription Referral Form 1

Send your RX to: Access Specialty Pharmacy
Fax: 661-489-3553

If you have any questions or concerns,
Please contact us at 661-489-3500 or toll free (833-647-0821)

Date Medication Needed: _____ Deliver to: ☐ Patient's home ☐ Prescriber's office ☐ Pick-up

Injection training by pharmacy? _____

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. Kg.
Soc. Sec #: _____ Preferred Phone: _____ Known Allergies: _____ BSA: _____ m2
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please Fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Provider Name: _____ DEA #: _____ NPI#: _____
Address: _____ Phone: _____ Fax: _____
City, State, ZIP: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, Tests, with the prescription

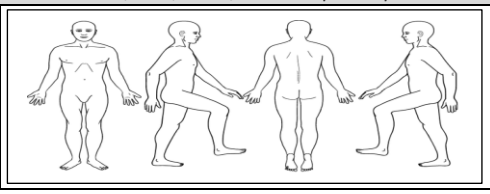
Date of diagnosis (or years with disease): _____

Has patient been treated previously for this condition? ☐ Yes ☐ No
If yes, medication/therapy failed (length of therapy): _____

Has patient received PPD (tuberculosis) Skin Test? ☐ Yes ☐ No

Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No

Does patient have a latex allergy? ☐ Yes ☐ No



_____ % BSA
Affected by Psoriasis

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Cosentyx**	☐ 300 mg Sensoready Pen ☐ 150mg Sensoready Pen	**Starter Loading Dose:** Inject SC at weeks 0, 1, 2, 3 and 4 **Maintenance Dose**: Inject SC every 4 weeks. **Other**: _____		**0 refills for starter dose**
☐ **Dupixent**	300mg/2ml Prefilled Syringe	**Starter Dose:** Inject 600mg SC divided in 2 different injection sites **Maintenance Dose:** 300mg SC every other week		**0 refills for starter dose**
☐ **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 3 months) **Maintenance Dose:** Inject 50mg SC once a week. **Other**: _____		**0 refills for starter dose**
☐ **Humira**	☐ 40mg/0.8ml Pens (2 doses) ☐ 40mg/0.8ml Prefilled Syringe (2 doses) ☐ 40mg/ 0.8ml Pens (4 doses) ☐ 80mg/0.8ml Pens (2 doses) ☐ 40mg/ 0.8ml Starter Kit (6 doses) ☐ 80mg/0.8ml Starter Kit pens (3 doses)	**Starter Dose:** Hidradentitis 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:** Hidradentitis Suppurativa: Inject 40 mg SC on day 29 and then every week thereafter Plaque Psoriasis: Inject 40mg SC every 2 weeks. Other: _____		**0 refills for starter dose**

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ **Date:** _____

Prescriber Signature: Prescriber, please sign and date below

_____ _____ _____ _____
Dispense as written **Date** **Substitution Permissible** **Date**

# of Prescriptions:

I authorize Access Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process