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 2

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

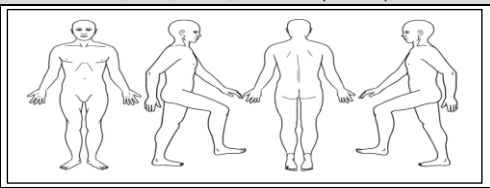
Date of diagnosis (or years with disease): _____

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
☐ **Otezla**	☐ 10mg tab	☐ 20 mg tab ☐ 30mg tab		
☐ **Siliq**	☐ 210mg/1.5ml Prefilled Syringe	**Starter Dose:** Inject 210 mg SC on weeks 0, 1, and 2 **Maintenance Dose:** Inject 210 mg SC every 2 weeks.		**0 refills for starter dose**
☐ **Stelara**	☐ 45mg/0.5ml Prefilled Syringe ☐ 90mg/ml Prefilled Syringe	**Starter Dose:** ☐ Inject 45 mg SC (patient ≤ 100 kg) at day 1 ☐ Inject 90 mg SC (Patient > 100 kg) at day 1 **Maintenance Dose:** ☐ Inject 45 mg SC (patient ≤ 100 kg) on Day 29 and then every 12 weeks ☐ Inject 90mg SC (Patient > 100 kg) on Day 29 and then every 12 weeks Other: _____		**0 refills for starter dose**
☐ **Taltz**	☐ 80mg/ml Autoinjector ☐ 80mg/ml Prefilled Syringe	**Starter Dose:** ☐ Inject 160 mg SC at week 0, then inject 80 mg SC at week 2 **Maintenance Dose:** ☐ Inject 80mg SC at week 4, 6, 8, and 10 ☐ Inject 80mg SC at week 12 and every 4 weeks thereafter		**0 refills for starter dose**
☐ **Tremfya**	☐ 100mg/ml Prefilled Syringe	**Starter Dose: Inject 100mg SC at weeks 0 and 4** **Maintenance Dose: Inject 100mg SQ every 8 weeks**		**0 refills for starter dose**
☐ **Valchlor**	☐ 0.016% Gel (60 gram)	☐ Apply a thin film once daily to the affected area of the body. **Other:** _____		

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