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 3

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

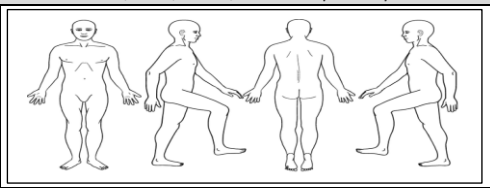
Date of diagnosis (or years with disease): _____

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
☐ **Simponi**	☐ 50mg/0.5ml Autoinjector ☐ 50mg/0.5ml Prefilled Syringe (Prescribe non-biologic DMARD in "Other" space, if applicable)	☐ Inject 50 mg SC once a month ☐ **Other:** _____		
☐ **Skyrizi**	☐ 150mg Dose (contains 2 prefilled syringes 75mg/0.83ml each)	**Starter Dose:** Inject two doses of 75mg each for a total of 150mg SC at week 0 and 4 **Maintenance Dose:** Inject 150mg SC every 12 weeks thereafter		0 refills on starter dose
☐ **Xeljanz**	☐ 5 mg tab (Prescribe non-biologic DMARD in "Other" space, if applicable)	☐ Take 5 mg by mouth twice daily ☐ Other: _____		
☐ **Xeljanz RX**	☐ 11 mg tab (Prescribe non-biologic DMARD in "Other" space, if applicable)	☐ Take 11 mg by mouth once daily ☐ 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