Pharmacy HyVee SOLUTIONS

DERMATOLOGY REFERRAL FORM A-H

877.RxHyVee (877.794.9833)
10004 S. 152nd Street, Suite C
Omaha, NE 68138

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
SSN		
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax		

Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Diagnosis: L20._____ Atopic Dermatitis L40.0 Psoriasis vulgaris/Plaque psoriasis/Nummular psoriasis L40.8 Other psoriasis
L40.9 Psoriasis, unspecified L40.5____ Psoriatic arthritis L73.2 Hidradenitis Suppurativa Other: _____

Date of diagnosis or years with the disease: _____

Active TB is ruled out: Yes No Date of negative TB test: _____/_____/_____

Concomitant medications: _____

Previous treatment regimens with dates and reason for discontinuation: _____

Prescription Information

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QTY	REFILLS
Cimzia (Vials to be prepared and administered by healthcare professionals)	❑ 200mg/mL Prefilled Syringes ❑ 200mg/mL Vials	**Starter Dose:** ❑ Inject 400mg SQ at weeks 0, 2 and 4	6	0
		Maintenance Dose: ❑ Inject 400mg SQ every 4 weeks ❑ Inject 200mg SQ every 2 weeks	28 day	
Cosentyx	❑ 150mg/mL Sensoready Pen ❑ 150mg/mL Prefilled Syringe	**Starter Dose:** ❑ Inject 300mg SQ once weekly at weeks 0, 1, 2, 3 and 4 ❑ Inject 150mg SQ once weekly at weeks 0, 1, 2, 3 and 4	10 5	0
		Maintenance: ❑ Inject 300mg SQ every 4 weeks ❑ Inject 150mg SQ every 4 weeks	28 day	
Enbrel	❑ 50mg/mL Sureclick Autoinjector ❑ 50mg/mL Prefilled Syringe ❑ 25mg/0.5mL Prefilled Syringe ❑ 25mg/mL vial ❑ Enbrel® Mini	**Starter Dose:** ❑ Inject 50mg SQ twice a week (72-96 hrs apart) x 3 months (Psoriasis) ❑ Other:	28 day	2
		Maintenance Dose: ❑ Inject 50mg SQ once weekly ❑ Inject 25mg SQ twice weekly (72-96 hrs apart) ❑ Other:	28 day	
Humira	❑ 40mg/0.8mL Pens ❑ 40mg/0.8mL Prefilled Syringes	❑ **Psoriasis Starter Pack:** Inject 80mg SQ Day 1, then 40mg on Day 8, then 40mg every other week thereafter	4	0
		Hidradenitis Suppurativa: ❑ Inject 160mg SQ on Day 1, 80mg SQ on Day 15, then 40mg every week thereafter **-OR-** ❑ Inject 80mg SQ on Day 1 and Day 2, 80mg SQ on Day 15, then 40mg every week thereafter	6	0
		Maintenance Dose: ❑ Inject 40mg SQ every other week ❑ Inject 40mg SQ on day 29 and every week thereafter (Hidradenitis Suppurativa)	28 day	

Date needed: _____/_____/_____ Medication delivery to (choose one): ❑ Prescriber ❑ Home ❑ Other:

Injection training to be provided by: ❑ Prescriber's Office ❑ Hy-Vee Pharmacy Solutions ❑ Other:_____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)