Pharmacy SOLUTIONS Hy-Vee

DERMATOLOGY REFERRAL FORM I-Z

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

Patient Information

Last Name	First Name	DOB
Address		
City	State	ZIP
SSN		
Sex	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
Otezla	❑ Titration Starter Pack	**Titration Dose:** ❑ Take by mouth as directed per package instructions (directions for Titration Starter Pack only)	1 pack	0
	❑ Bridge Dose Pack	**Bridge Dose:** ❑ Take 30mg by mouth twice daily (Bridge) ❑ Take 30mg by mouth once daily (Bridge)	28 day	
	❑ 30mg Tablet	**Maintenance Dose:** ❑ Take 30mg by mouth twice daily ❑ Take 30mg by mouth once daily	30 days	
Remicade Current Weight ________kg	❑ 100mg Vial	**Starter Dose:** ❑ Infuse 5mg/kg (_________mg) IV at week 0, week 2 and week 6, followed by 5 mg every 8 weeks thereafter	__vials	0
		Maintenance Dose: ❑ Infuse 5mg/kg (_________mg) IV every 8 weeks	56 day	
Simponi	❑ 50mg/0.5mL SmartJect Pen ❑ 50mg/0.5mL Prefilled Syringe	❑ Inject 50mg SQ once a month	30 day	
Stelara Current Weight ________kg	❑ 45mg/0.5mL Prefilled Syringe (patients weighing <100 kg)	**Patients <100kg:** ❑ INITIAL DOSE: Inject 45mg SQ on Day 0 and Day 28	2	0
		❑ MAINTENANCE DOSE: Inject 45mg SQ every 12 weeks	84 day	
	❑ 90mg/1mL Prefilled Syringe (patients weighing >100 kg)	**Patients >100kg:** ❑ INITIAL DOSE: Inject 90mg SQ on Day 0 and Day 28	2	0
		❑ MAINTENANCE DOSE: Inject 90mg SQ every 12 weeks	84 day	
Taltz	❑ 80mg/1mL Autoinjector ❑ 80mg/1mL Prefilled Syringe	**Starter Dose:** ❑ Inject 160mg SQ at week 0, then 80mg SQ every 2 weeks (weeks 2-12)	8	0
		Maintenance: ❑ Inject 80mg SQ every 4 weeks (start after 12 initial weeks)	28 day	
Tremfya	❑ Prefilled Syringe	**Starter Dose:** ❑ Inject 100mg SQ at week 0, then 100mg at week 4 and every 8 weeks thereafter	2 x 100 mg/ml	0
		Maintenance: ❑ Maintenance dose: Inject 100mg SQ every 8 weeks	1 x 100 mg/ml	0

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: ____

PRESCRIBER MUST MANUALLY SIGN THIS FORM - *(STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED)*

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) **DISPENSE AS WRITTEN/Do Not Substitute (date)**

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