

Prescriber's Signature:

Date Shipment Needed:	_Ship To: □Patient □Prescriber
□ Nursing needed; □ Training needed ► All the supplies including syringes a	nd needles will be dispensed if needed.

Phone: 1-800-275-0139 • Fax: 843-972-9395

## **DERMATOLOGY REFERRAL FORM**

atient Name:			200		211	1		
			DOB:	Sex: □M □F □	Other:	Weight:	[	□ lbs. □
SN:	Phone:		Allergies:	100	101 :	1		
ddress:			l Di	City:	State:	Zip:		
mergency Contact:	MATION		Phone:		☐ Addition	al Information Attach	ned	
RESCRIBER INFOR rescriber:	WATION		NPI:	DEA:		State Lic:		
pervising Physician	•		INFI.	Practice Name:		State Lic.		
· · · · · · · · · · · · · · · · · · ·	•			•	Ctata	7in:		
ddress:		F		City:	State:	Zip:		
none:	ATION / MEDICAL ASS	Fax:		Key Office Contact:		Phone:		
Location: Hands Severity: Mild (up to 50.1 Chronic Idiopathic eated previously for this erange of previous the Is patient currently on Will patient stop taking Has patient received Prior to initiating treat ESCRIPTION INFO	□ Feet □ Face □ Scalp □ o 3% BSA) □ Moderate (3 c Uticaria s condition, please indicate prapy: □ Type □ No Type of the above medication(s) be a PPD (tuberculosis) Skin Tement and periodically during IRMATION of will include the following:	Groin □Nails □0-10% BSA) □Severe which drugs have been per medication(s): □efore starting the new fest? □Yes □No Reg therapy, patient should the per medication (1) dispensing ordered	Others:e (greater than 10% en triedand failed: en medication? □Ye esults: uld be evaluated for dimed/dose, (2) dilu	BSA), BSA  S No, if yes, how long show active tuberculosis and tester to mix and/or dilute doses before orally (Apap 325 mg		ore starting the new medic n. I line and anakit med (epir	cation?	B mg IM /
□ 1 tablet po  osentyx™ 150 mg/mL  oready® pen will be dispense	. Sensoready® Pen □Cos			Cosentyx™150 mg Vial of I		QTY: 1 month	F	Refills:
☐ Starter Dose not ☐ Maintenance Do	0 mg SQ initially (Weeks 0, needed se: 300 mg SQ every 4 We	eks	0 mg SQ every 4 W	eeks thereafter (Week 4)		QTY: <u>5 weeks</u> QTY: <u>1 month</u>		Refills: <u>0</u> Refills:_
□ Starter Dose not □ Maintenance Do □ Other □ Uppilumab □ Starter Dose: Inj □ Starter Dose not □ Maintenance Do  Inbrel® 50 mg/ml Sure Click will be dispensed if no p □ Starter Dose: 50	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector . 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe):  cClick (autoinjector) □ Enb reference indicated mg SQ twice weekly (72-96)	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks  rel® 50 mg Prefilled S	umab) 300 mg pref Veeks starting on Da Syringe □Enbrel® I	illed syringe *pen will be dispens ay 15	sed if no preference indica	QTY: 1 month	r <u>ter</u> f F ven® Progran	Refills:_ Refills:_0 Refills:_
□ Starter Dose not □ Maintenance Do □ Other □ upixent® (Dupilumab □ Starter Dose: Inj □ Starter Dose not □ Maintenance Do  nbrel® 50 mg/ml Sure Click will be dispensed if no p □ Starter Dose: 50 □ Starter Dose not □ Maintenance Do	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe):  cClick (autoinjector) □ Enb reference indicated mg SQ twice weekly (72-96) needed se: 50 mg SQ weekly □ O	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks rel® 50 mg Prefilled S hours apart) for 3 mc ther	umab) 300 mg pref Veeks starting on Da Syringe □Enbrel® I	illed syringe *pen will be dispen: ay 15 Mini 50 mg Cartridge		QTY: 1 month  QTY: QS for star  QTY: 1 month  □ Enroll in Enliv	r <u>ter</u> F F ven® Progran	Refills:_ Refills:_0 Refills:_ n
□ Starter Dose not □ Maintenance Do □ Other □ Starter Dose: Inj □ Starter Dose not □ Maintenance Do    Starter Dose not □ Maintenance Do   Starter Dose: 50 □ Starter Dose not □ Maintenance Do   Starter Dose not   Starter Dose   Starter Dose	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe):  cClick (autoinjector) □ Enb preference indicated mg SQ twice weekly (72-96) needed se: 50 mg SQ weekly □ O  Prefilled Syringe □ Enbu	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks  rel® 50 mg Prefilled S hours apart) for 3 mc ther  rel® 25 mg Single-Use	umab) 300 mg prefi Veeks starting on Di Syringe □Enbrel® I onths	illed syringe *pen will be dispen: ay 15 Mini 50 mg Cartridge	cated	QTY: 1 month  QTY: QS for star  QTY: 1 month  □ Enroll in Enliv  QTY: 1 month	r <u>ter</u> F rven® Progran _ F	Refills:_ Refills:_0 Refills:_ n Refills:_2
Starter Dose not  Maintenance Do  Other	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector . 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe):  cClick (autoinjector) □ Enb reference indicated mg SQ twice weekly (72-96 needed se: 50 mg SQ weekly □ O  Prefilled Syringe □ Enb reekly (72-96 hours apart) [ sules Take 1 Capsule Oral	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks  rel® 50 mg Prefilled S hours apart) for 3 mc ther  rel® 25 mg Single-Use  Other  ly Once Daily	umab) 300 mg pref Veeks starting on Da Syringe □Enbrel® I onths	illed syringe *pen will be dispensay 15  Mini 50 mg Cartridge  will be dispensed if no preference indi	icated	QTY: 1 month  QTY: QS for star  QTY: 1 month  □ Enroll in Enliv  QTY: 1 month  QTY: 1 month	r <u>ter</u> F rven® Progran _ F	Refills:_ Refills:_ Refills:_ n Refills:_ Refills:_
□ Starter Dose not □ Maintenance Do □ Other □ Oupixent® (Dupilumab □ Starter Dose: Inj □ Starter Dose not □ Maintenance Do  Enbrel® 50 mg/ml Sure □ Starter Dose: 50 □ Starter Dose not □ Maintenance Do  Enbrel® 25 mg/0.5 mL □ 25 mg SQ twice we  Erivedge® 150 mg Cap  Humira® CF Pen Psori	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector . 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe): cClick (autoinjector) □ Enb veference indicated mg SQ twice weekly (72-96 needed se: 50 mg SQ weekly □ O  Prefilled Syringe □ Enbu veekly (72-96 hours apart) □ sules Take 1 Capsule Oral asis Starter Kit NDC: 0074-	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks  rel® 50 mg Prefilled S hours apart) for 3 mc ther  rel® 25 mg Single-Use  Other  ly Once Daily	umab) 300 mg pref Veeks starting on Da Syringe □Enbrel® I onths	illed syringe *pen will be dispensay 15  Mini 50 mg Cartridge will be dispensed if no preference indi	icated	QTY: 1 month  QTY: QS for star  QTY: 1 month  □ Enroll in Enliv  QTY: 1 month  QTY: 1 month  QTY: 1 month	rter F ven® Program  F F ces F	Refills: Refills:_0 Refills:_ n Refills:_2 Refills:_ Refills:_
□ Starter Dose not □ Maintenance Do □ Other □ Oupixent® (Dupilumab □ Starter Dose: Inj □ Starter Dose not □ Maintenance Do  Enbrel® 50 mg/ml Sure □ Starter Dose: 50 □ Starter Dose not □ Maintenance Do  Enbrel® 25 mg/0.5 mL □ 25 mg SQ twice we  Erivedge® 150 mg Cap  Starter Kit will be dispensed if	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector . 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe):  cClick (autoinjector) □ Enb reference indicated mg SQ twice weekly (72-96 needed se: 50 mg SQ weekly □ O  Prefilled Syringe □ Enb reekly (72-96 hours apart) □ sules Take 1 Capsule Oral asis Starter Kit NDC: 0074-1 not checked  Psoriasis: □ One 80 mg S □ Two 40 mg S6	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks  rel® 50 mg Prefilled S hours apart) for 3 mo ther  rel® 25 mg Single-Use  Other  ly Once Daily  1539-03 □ Humira® Pr Q inj. Day 1, one 40 m	umab) 300 mg pref Neeks starting on Da Syringe □Enbrel® I onths e Vial *Prefilled Syringe efilled Syringe CF ng SQ inj. Day 8, on	illed syringe *pen will be dispensay 15  Mini 50 mg Cartridge  will be dispensed if no preference indi	cated 243-02	QTY: 1 month  QTY: QS for star  QTY: 1 month  □ Enroll in Enliv  QTY: 1 month  QTY: 1 month  QTY: 1 month  QTY: 28 capsule	rter F ven® Program F F ira Complet	Refills: _0 Refills: _0 Refills: _ n Refills: _2 Refills: _
Starter Dose not Maintenance Do Other	needed se: 300 mg SQ every 4 We  ) 300 mg pen autoinjector 600 mg SQ on Day 1, then needed se: Inj. 300 mg (1 syringe):  cClick (autoinjector) □ Enb reference indicated mg SQ twice weekly (72-96 needed se: 50 mg SQ weekly □ O  Prefilled Syringe □ Enbu reekly (72-96 hours apart) □ relevence Take 1 Capsule Oral asis Starter Kit NDC: 0074- frot checked Psoriasis: □ One 80 mg S □ Two 40 mg SG needed. mL Pen NDC: 0074-0554-02	eks  Dupixent® (Dupilu 300 mg SQ every 2 V SQ every 2 Weeks  rel® 50 mg Prefilled S hours apart) for 3 mc ther  Other  Joher  Joher  Q inj. Day 1, one 40 m Q inj. Day 1, one 40 m	umab) 300 mg prefiveks starting on Dasselveks starting st	illed syringe 'pen will be dispensay 15  Wini 50 mg Cartridge  Will be dispensed if no preference indi  40 mg/ 0.4 mL NDC: 0074-02  e 40 mg SQ inj. Day 22 (ORe e 40 mg SQ inj. Day 22	cated 243-02	QTY: 1 month  QTY: QS for star  QTY: 1 month  □ Enroll in Enliv  QTY: 1 month  QTY: 1 month  QTY: 28 capsule  □ Enroll in Humi  QTY: 3 pens	rter F ven® Program F F ira Complet	Refills:_C Refills:_C Refills:_  Refills:_C Refills:_C Refills:_C Refills:_C Refills:_C Refills:_C Refills:_C Refills:_C

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. Prescriber authorizes Palmetto Specialty Pharm to forward this prescription to another pharmacy, if needed.

☐ DAW (Dispense as Written)

Date:



Date Ship	oment Needed:	Ship To: □ Patient □ Prescriber
$\square$ Nursing needed; $\square$ Training needed $\blacktriangleright$	All the supplies including syrin	ges and needles will be dispensed if needed.

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## **DERMATOLOGY REFERRAL FORM**

DATIENT INFORMATION					
PATIENT INFORMATION Patient Name:			DOB:		
Address:		City:	State:	Zip:	
INSURANCE INFORMATION		Oity.	State.	Ζιρ.	
☐ Please attach front and back of patient's insur	ance card (medical and prescript	ion)			
COPAY CARD ENROLLMENT	ance card (medical and prescript				
□ Please check if enrolling in copay card	Copay ID:				
PRESCRIPTION INFORMATION	copul is:				
□ STC Standard Protocol will include the following: (1) dimg IM (for pediatric patients) and diphenhydramine 50 mg/	spensing ordered med/dose, (2) diluent mL) and (4) premeds to take 30 mins be	to mix and/or dilute dose, (3) flusher fore orally (Apap 325 mg, may repe	s to flush line a at x1, and diph	and anakit med (epinephrine 0 enhydramine 25 mg, may repe	.3 mg IM / 0.15 eat x1).
☐ Humira® Starter Pkg CF 80 mg/0.8 mL Pen NDC: 0074- *Pen will be dispensed if no preference indicated	0124-03 □ Humira® CF Prefilled Syring	ge 40 mg/0.4 mL NDC: 0074-0243-02			
☐ Starter Dose for Hidradenitis Suppurativa: ☐				QTY: 1 month	Refills: 0
	Inj 80 mg SQ day 1, and 80 mg SQ day	2, then 80 mg SQ day 15		QTY: 1 month	Refills: 0
☐ Starter Dose not needed.					
□ Humira® CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 □ H	umira® CF 40 mg/0.4 mL Syringe NDC:	0074-0243-02			
☐ Maintenance Dose for Hidradenitis Suppurative	va: 40 mg SQ Day 29 and every week th	nereafter		QTY: 1 month	Refills:
☐ Other				QTY:	Refills:
☐ Ilumya™ 100 mg/mL Prefilled Syringes					
☐ Starter Dose: 100 mg SQ on Week 0 and Week	ek 4			QTY: 1 month (1 PFS)	Refills: 0
☐ Maintenance Dose: 100 mg SQ every 12 wee				QTY: 1 syringe	Refills:
☐ Kevzara® (Sarilumab) pen autoinjector 200 mg/1.14 r	nL □Kevzara® (Sarilumab) prefilled s	yringe 200 mg/1.14 mL			
*Pens will be dispensed if no preference is indicated				OTV: 1 hav: (0)	Defille
☐ 200 mg subcutaneously every 2 Weeks				QTY: <u>1 box (2)</u>	Refills:
□ Odomzo® 200 mg Capsule PO Once Daily				QTY: 30 caps	Refills:
□ Otezla® Tablets					
☐ Titration Dose: Day 1: 10 mg in morning; Day 2: 10	mg in morning and 10 mg in evening; I	Day 3: 10 mg in morning and 20 mg	in evening;	QTY: 1 month	Refills: 0
Day 4: 0 mg in morning and 20 mg in evening; Day	5: 20 mg in morning and 30 mg in even	ning; Day 6 and thereafter: 30 mg tw	ice daily		
☐ Maintenance Dose: 30 mg twice daily ☐ Other				QTY: <u>60 tabs (30mg)</u>	Refills:
			_	QTY:	Refills:
□ Remicade® 100 mg Vial □ Inflectra® 100 mg Powder □ MD's Office Infusion □ Home Infusion Supplies Requ		al 🗌 Avsola® 100 mg Powder V	ial	☐ Enroll in AccessOne	SM Program
☐ Starter Dose:mg IV on We				QTY: QS 3 infusions	Refills: 0
☐ Maintenance Dose:mg IV ev	eryWeeks			QTY: QS 1 infusions	Refills:
☐ Rinvoq 15mg tablet ☐ Rinvoq 30mg tablet					
☐ 1 tablet po once daily				QTY: 1 month	Refills:
☐ Siliq® 210 mg/1.5 mL Prefilled Syringe (2 pack)				☐ Enroll in REMS Progr	
☐ Starter Dose for Plaque Psoriasis: 210 mg SQ at weeks 0, 1 and 2, followed by maintenancedose.				QTY: 1 box (2 PFS)	
☐ Maintenance Dose for Plaque Psoriasis: 210 mg \$	SQ once every two weeks. (starting at w	reek2)		QTY: 1 box (2 PFS)	Refills:
☐ Simponi® Aria 50 mg/4 mL Patient weight(kg):				☐ Enroll in SimponiOne	e® Program
☐ Starter Dose: 2 mg/kg IV at weeks 0 and 4				QTY: 1 month	Refills: 0
☐ Maintenance Dose: 2 mg/kg IV every 8 weeks				QTY: QS for 8 weeks	Refills:
☐ Simponi® SmartJect 50 mg/0.5 mL ☐ Simponi® Prefil	led Syringe 50 mg/0 5 ml *Pans will be dis	enanced if no preference is indicated			
□ 50 mg SQ every month	ica cyringe oo mg/o.c me 7 ens wii be dis	spensed ii no preference is maicated		QTY: 1 month	Refills:
Other:				QTY:	Refills:
☐ Skyrizi® Pen autoinjector 150mg/mL ☐ Skyrizi® prefil	led syringe 150mg/ml *Pens will be dispens	sed if no preference is indicated			
☐ Starter dose: 150 mg SQ at Week 0 and 4				QTY: 1	Refills: 0
☐ Maintenance Dose: 150 mg SQ every 12 Weeks				QTY: <u>1</u>	Refills:

Prescriber's Signature: DAW (Dispense as Written)

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. Prescriber authorizes Palmetto Specialty Pharm to forward this prescription to another pharmacy, if needed.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to Palmetto Specialty Pharm or any of its subsidiaries using the contact information provided on this coversheet.



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□ Nursing needed; □ Training needed ► All the supplies including syring	nges and needles will be dispensed if needed.

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## **DERMATOLOGY REFERRAL FORM**

PATIENT INFORMATION					
Patient Name:		DC	)B:		
Address:	City:	Sta	ate:	Zip:	
INSURANCE INFORMATION					
☐ Please attach front and back of patient's insurance card (medical a	nd prescription)				
COPAY CARD ENROLLMENT					
☐ Please check if enrolling in copay card Copay ID:					
PRESCRIPTION INFORMATION					
□ STC Standard Protocol will include the following: (1) dispensing ordered med/domg IM (for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds to to					
☐ Stelara® Prefilled Syringe ☐ Stelara® Vial ☐ MD's Office Infusion ☐ Home Infu	sion Supplies Required			☐ Enroll in Janssen C	arePath Program
□ ≤ 100 kg Starter Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 \rangle	Weeks of initial dose (week4)			QTY: 1 x 45mg	Refills: 1
□ ≤ 100 kg Maintenance Dose: 45 mg SQ every 12 Weeks □ Other				QTY: 1 x 45mg	Refills:
$\square$ > 100 kg Starter Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 V	Veeks of initial dose (week 4)			QTY: 1 x 90mg	Refills: 1
☐ > 100 kg Maintenance Dose: 90 mg SQ every 12 Weeks ☐ Other				QTY: 1 x 90mg	Refills:
☐ Taltz® Autoinjector 80 mg/mL ☐ Taltz® Prefilled Syringe 80 mg/mL *Pens will be	dispensed if no preference is indicated				
☐ Starter Dose for Plaque Psoriasis: 160 mg (two 80 mg inj.) at Week 0, then	80 mg at Week2,4,6,8,10,12			QTY: 8	Refills: 0
☐ Maintenance Dose for Plaque Psoriasis: 80 mg every 4 weeks	-			QTY: 1	Refills:
☐ Starting Dose for Psoriatic Arthritis: 160 mg (two 80 mg inj.) at Week0				QTY: <u>2</u>	Refills: 0
☐ Maintenance Dose for Psoriatic Arthritis: 80 mg every 4 Weeks				QTY: <u>1</u>	Refills:
□ Other				QTY:	Refills:
│ □ Tremfya® pen autoinjector 100 mg/mL □Tremfya® prefilled syringe 100 mg	/ml *Dan will be dispensed if an austrones	in indicated			
☐ Starter Dose: 100 mg SQ at Week 0, 4, and every 8 Weeks thereafter	THE Peri will be dispensed if no preference i	is indicated		QTY: 1	Refills: 0
☐ Maintenance Dose: 100 mg SQ every 8 Weeks (starting at week 4)				QTY: 1	Refills:
				Q11	1.011110
□ Xeljanz® 5mg tablet □Xeljanz 10mg tablet □Xeljanz 11mg ERtablet					
□ 5mg tablet po twice daily				QTY: 1 month	Refills:
□ 10mg tablet po twice daily				QTY: 1 month	Refills:
☐ 11mg tablet po once daily				QTY: <u>1 month</u>	Refills:
□ Xolair® 150 mg PFS □ Xolair® 150 mg vial					
☐ 150mg ☐ 300mg SQ every 4 Weeks				QTY:28 day supply	Refills:
· · · · · · · · · · · · · · · · · · ·					

Physician's Signature: DAW (Dispense as Written)

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.