DERMATOLOGY REFERRAL FORM

(Specialty Pharmacy A-C)

FLEXCARE SPECIALTY SERVICES

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • Recent Clinicals & Labs • Patient Demographics • Tried/Failed Therapies • Neg TB • Med List

PRIMARY DIAGNOSIS

☐ L20.9 Atopic Dermatitis, unspecified
☐ L40.0 Moderate to Severe Psoriasis Vulgaris
☐ L40.59 Psoriatic Arthritis, unspecified
☐ L73.2 Hidradenitis suppurativa
☐ Other:_____

PRIMARY MEDICATION ORDER

☐ New ☐ Refill | Ship by: ____/____/_____ | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Adbry	☐ Pre-filled syringe	☐ **INITIAL:** Inject 600mg (4 x 150mg) SubQ on day 1 (Qty: 4) ☐ **MAINTENANCE:** Inject 300mg (2 x 150mg) SubQ every other week, starting at day 15 (Qty: 4) ☐ **MAINTENANCE:** Inject 300mg (2 x 150mg) SubQ every 4 weeks (Qty: 2)	
Cibinqo	☐ 100 mg tablet ☐ 200 mg tablet	☐ Take 1 tablet PO once daily (Qty: 30)	
Cimzia	☐ Pre-filled syringe ☐ Vials	☐ Inject 400 mg SubQ every other week (Qty: 4)	
Cosentyx	☐ Sensoready Pen ☐ Pre-filled syringe	☐ **INITIAL:** Inject 150mg SubQ on week 0, 1, 2, and 3 (Qty: 4) ☐ **MAINTENANCE:** Inject 150mg SubQ on week 4, and every 4 weeks thereafter (Qty: 1) ☐ **INITIAL:** Inject 300mg SubQ on week 0, 1, 2, and 3 (Qty: 8) ☐ **MAINTENANCE:** Inject 300mg SubQ on week 4 and every 4 weeks thereafter (Qty: 2)	

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:		Office Contact:
Practice Name:		Phone:
Address:		☐ Email:
City, State, Zip:		☐ Fax:
NPI:	License:	Tax ID:

Provider Signature (no stamps) _____ Date _____

To Prescriber: By signing this form and utilizing our services, you are also authorizing FlexCare to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and copay assistance foundations.

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EMAIL: referrals@flexcarespecialty.com | VISIT: flexcareinfusion.com/referrals

DERMATOLOGY REFERRAL FORM

(Specialty Pharmacy D-E)

FLEXCARE SPECIALTY SERVICES

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

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☐ L40.59 Psoriatic Arthritis, unspecified
☐ L73.2 Hidradenitis suppurativa
☐ Other:_____

PRIMARY MEDICATION ORDER

☐ New ☐ Refill | Ship by: ____/____/_____ | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

DRUG		DIRECTIONS & QUANTITY			REFILLS
		CRITERIA	INITIAL Dose	MAINTENANCE Dose	
Dupixent	☐ Pre-filled syringe	☐ ≥ 18 yr old	600mg (2 x 300mg) SubQ on day 1 (Qty:2)	300mg SubQ q2w, starting on day 15 (Qty:2)	
		☐ Age 6-17 yrs, 15 to <30 kg	600mg (2 x 300mg) SubQ on day 1 (Qty:2)	300mg SubQ q4w, starting on day 29 (Qty:2)	
		☐ Age 6-17 yrs, 30 to <60 kg	400mg (2 x 200mg) SubQ on day 1 (Qty:2)	200mg SubQ q2w, starting on day 15 (Qty:2)	
		☐ Age 6-17 yrs, ≥ 60 kg	600mg (2 x 300mg) SubQ on day 1 (Qty:2)	300mg SubQ q2w, starting on day 15 (Qty:2)	
		☐ Age 6mo-5yr, 5 to <15 kg	200mg (1 x 200mg) SubQ on day 1 (Qty:1)	200mg SubQ q4w, starting on day 29 (Qty:1)	
		☐ Age 6mo-5yr, 15 to <30 kg	300mg (1 x 300mg) SubQ on day 1 (Qty:1)	300mg SubQ q4w, starting on day 29 (Qty:1)	
Enbrel	☐ SureClick Pen ☐ Pre-filled syringe	☐ **INITIAL:** Inject 50mg SubQ twice weekly (72-96 hrs apart) x 3 months (Qty: 8 with 2 refills) ☐ **MAINTENANCE:** Inject 50mg SubQ weekly (Qty: 4)			

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DERMATOLOGY REFERRAL FORM

(Specialty Pharmacy H-R)

FLEXCARE SPECIALTY SERVICES

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

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PRIMARY DIAGNOSIS

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☐ L73.2 Hidradenitis suppurativa
☐ Other:_____

PRIMARY MEDICATION ORDER

☐ New ☐ Refill | Ship by: ____/____/_____ | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Humira	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled syringe	☐ **INITIAL:** Inject 80mg SubQ on day 1, 40mg on day 8, then 40mg every other week (Qty: qs 28 days) ☐ **MAINTENANCE:** Inject 40mg SubQ every other week (Qty: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled syringe	☐ **INITIAL:** Inject 160mg SubQ on day 1, then 80mg SubQ on day 15 (Qty: qs 28 days) ☐ **MAINTENANCE:** Inject 80mg SubQ every other week, starting day 29 (Qty: 2) **PEN ONLY** ☐ **MAINTENANCE:** Inject 40mg SubQ weekly, starting day 29 (Qty: 4)	
Ilumya	☐ Pre-filled syringe	☐ **INITIAL:** Inject 100mg SubQ on weeks 0 & 4 (Qty: 1 with 1 refill) ☐ **MAINTENANCE:** Inject 100mg SubQ every 12 weeks thereafter (Qty: 1)	
Olumiant	☐ 1 mg tablet ☐ 2 mg tablet ☐ 4 mg tablet	☐ Take 1 tablet PO once daily (Qty: 28)	
Otezla	☐ 4-Week Starter Kit	☐ **INITIAL:** Titrate dose per Starter Kit (Qty: 1 kit)	
	☐ 30mg tablet	☐ **MAINTENANCE:** Take 1 tablet PO twice daily (Qty: 56)	
Rinvoq	☐ 15mg tablet ☐ 30mg tablet	☐ Take 1 tablet PO once daily (Qty: 28)	

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DERMATOLOGY REFERRAL FORM

(Specialty Pharmacy S-Z)

FLEXCARE SPECIALTY SERVICES

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

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PRIMARY DIAGNOSIS

☐ L20.9 Atopic Dermatitis, unspecified
☐ L40.0 Moderate to Severe Psoriasis Vulgaris
☐ L40.59 Psoriatic Arthritis, unspecified
☐ L73.2 Hidradenitis suppurativa
☐ Other:_____

PRIMARY MEDICATION ORDER

☐ New ☐ Refill | Ship by: ____/____/_____ | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Siliq	☐ Pre-filled syringe	☐ **INITIAL:** Inject 210mg SubQ on weeks 0 & 1 (Qty: 2) ☐ **MAINTENANCE:** Inject 210mg SubQ every 2 weeks, starting at week 2 (Quantity: 2)	
Skyrizi	☐ Pen ☐ Pre-filled syringe	☐ **INITIAL:** Inject 150mg SubQ on weeks 0 & 4 (Qty: 1 with 1 refill) ☐ **MAINTENANCE:** Inject 150mg SubQ every 12 weeks (Qty: 1)	
Sotyktu	☐ 6 mg tablet	☐ Take 1 tablet PO daily with or without food (Qty: 28)	
Stelara	☐ 45mg Pre-filled syringe (for ≤100kg/220lbs)	☐ **INITIAL:** Inject 45mg SubQ on weeks 0 & 4 (Qty: 1 with 1 refill) ☐ **MAINTENANCE:** Inject 45mg SubQ every 12 weeks (Qty: 1)	
	☐ 90mg Pre-filled syringe (for >100kg/220lbs)	☐ **INITIAL:** Inject 90mg SubQ on weeks 0 & 4 (Qty: 1 with 1 refill) ☐ **MAINTENANCE:** Inject 90mg SubQ every 12 weeks (Qty: 1)	
Taltz	☐ Auto-Injector ☐ Pre-filled syringe	☐ **STARTING:** Inject 160mg (2 x80mg) SubQ at week 0, then begin first induction dose 80mg (1 x 80mg) on week 2 (Qty: 3) ☐ **INDUCTION:** Inject 80mg SubQ every 2 weeks for weeks 4-10 (Qty: 2 with 1 refill) ☐ **FINAL INDUCTION:** Inject 80mg SubQ on week 12 (Qty: 1) ☐ **MAINTENANCE:** Inject 80mg SubQ every 4 weeks thereafter (Qty: 1)	
Tremfya	☐ One-Press Injector ☐ Pre-filled syringe	☐ **INITIAL:** Inject 100mg SubQ on weeks 0 & 4 (Qty: 1 with 1 refill) ☐ **MAINTENANCE:** Inject 100mg SubQ every 8 weeks (Qty: 1)	

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