DERMATOLOGY (A-K) PRESCRIPTION REFERRAL FORM

REALO RX SPECIALTY CARE PHARMACY

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: ________ ❑Male ❑Female SS#: ________ DOB: ________
Address: ________ City, State, Zip: ________
Primary Phone: ________ ❑Home ❑Cell ❑Work Alternate Phone: ________ ❑Home ❑Cell ❑Work
Email: ________ Height: ________ Weight: ________
Allergies: ________ Comorbidities: ________

PRESCRIBER INFORMATION

Prescriber Name: ________ Office Contact: ________
Address: ________ City, State, Zip: ________
Phone: ________ Fax: ________
NPI: ________ DEA: ________

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: ________
Date Shipment Needed By: ________ ❑Alternate Location: ________
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis / ICD-10: ❑L40.0 Psoriasis ❑L40.59 Psoriatic Arthritis ❑L20 Atopic Dermatitis ❑L73.2 Hidradenitis Suppurativ... ❑Other: ________

Has patient received PPD (tuberculosis) Skin Test? (❑yes ❑no) Date of Negative Test: ________

Has Hepatitis B been ruled out? (❑yes ❑no) If no, has treatment been initiated (❑yes ❑no)

Does patient have a latex allergy: (❑yes ❑no)

________ % BSA affected by Psoriasis

Prior Failed Therapies:
❑Enbrel® ❑Stelara® ❑Humira®
❑Methotrexate® ❑Simponi® ❑PUVA
❑topical: ________

Do the affected areas include the palms, soles, head, neck or genitalia? (❑yes ❑no) Additional justification for drug: ________

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
❑Cosentyx® ❑Injection Training	Starter Dose: ❑Sensoready Pen ❑150 mg PFS ❑2 x 150 mg (300mg) PFS	❑4 boxes		❑150 mg Sub-Q once weekly for 5 weeks ❑300 mg Sub-Q once weekly for 5 weeks
	Maintenance Dose: ❑Sensoready Pen ❑150 mg PFS ❑2 x 150 mg (300mg) PFS	❑1 box		❑300 mg Sub-Q once weekly for 5 weeks ❑300 mg Sub-Q every 4 weeks
❑Cimzia® *only for PSA ❑Injection Training	Starter Dose: ❑Starter Kit (200 mg Prefilled Syringes) ❑200 mg lyophilized vial	❑1 Kit=6x200 mg/mL PFS ❑3 Kits=3 cartons of 2x200 mg vials		❑400 mg Sub-Q at weeks 0, 2, and 4
	Maintenance Dose: ❑200 mg/mL PFS	❑1 Carton = 2x200 mg/mL PFS		❑400 mg Sub-Q every 4 weeks
	❑200mg lyophilized vial	❑1 Carton = 2x200 mg vials		❑200 mg Sub-Q every 2 weeks
❑Dupixent®	❑2 mL	❑2 PFS ❑2 Prefilled Pens		❑Starter Pack: 600 mg Sub-Q (given as two 300 mg injections ❑Maintenance Dose: 300 mg Sub-Q once every other week
❑Enbrel®	❑25mg/mL vial kit	❑1 kit (4x1mL vials)		❑Children/Adolescents <63kg: 0.8mg/kg once weekly
❑Injection Training	❑50 mg/mL SureClick® Autoinjector	❑8		❑Psoriasis Induction Dose: Inject 50 mg Sub-Q twice a week (72-96 hours apart x 3 months)
	❑Mini 50 mg Prefilled Cartridge ❑50 mg/mL PFS ❑25 mg/0.5mL PFS	❑4		❑Inject 50 mg Sub-Q ONCE a week
❑Humira®	❑40 mg Pen ❑Citrate Free	❑1 kit		❑Starter Pack: 80 mg Sub-Q Day 1, then 40 mg one week later (Day 8), then 40 mg every other week thereafter
❑Injection Training	❑40 mg PFS	❑2		❑Maint. Dose: 40 mg Sub-Q every two weeks
❑Humira® HS	❑40 mg Pen ❑Citrate Free	❑1 kit		❑Starter Pack: 160 mg Sub-Q Day 1, then 80 mg 2 weeks later (Day 15)
	❑40 mg PFS	❑4		❑Maint. Dose: 40 mg Sub-Q every week
❑Injection Training	❑80 mg Pen	❑2		❑Maint. Dose: 80mg Sub-Q every two weeks
❑Ilumya®	❑100mg/mL PFS	❑1 PFS		❑Starter Pack: 100 mg Sub-Q at weeks 0 and 4 ❑Maintenance Dose: 100 mg Sub-Q once every 12 weeks

Patient Eligible for Self-Injection? ❑Yes ❑No

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature ________ Date ________ Substitution Permissable - Signature ________ Date ________

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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