DERMATOLOGY (M-Z) PRESCRIPTION REFERRAL FORM

REALO SPECIALTY CARE PHARMACY

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-194
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 ❑Phvsician/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 ❑40.59 Psoriatic Arthritis ❑.20 Atopic Dermatitis ❑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
Do the affected areas include the palms, soles, head, neck or genitalia? (❑yes ❑no) Additional justification for drug: _____

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

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
❑Odomzo®	❑200 mg	❑30		❑Take 1 capsule by mouth once daily
❑Otezla®	Starter Dose: ❑4-week starter pack	❑One 4 week starter pack		Day 1: 10 mg AM; Day 2: 10 mg AM, 10 mg PM; Day 3: 10 mg AM, 20 m PM; Day 4: 20 mg AM, 20 mg PM; Day 5: 20 mg AM, 30 mg PM; Day 6 a thereafter: 30 mg twice daily (as indicated on starter pack packaging)
	Bridge Program Dose Pack: ❑30 mg tablet	❑28-count carton of 30 mg tablets (two blister cards containing 14 tablets each)		❑30mg PO once daily (renal impairment)
	Maintenance Dose: ❑30 mg tablet	❑60 tablets		❑30 mg PO twice daily
❑Siliqi®	❑210 mg/1.5 mL PFS	❑2		❑Starter dose: Inject 1 syringe (210mg) at Weeks 0 and 1 ❑Maintenance dose: Starting at Week 2, inject 1 syringe (210mg) every 2 weeks
❑Simponi® *only for PSA	❑50 mg/0.5 mL SmartJect® Autoinjector ❑50 mg/0.5 mL PFS	❑1		❑50 mg Sub-Q once a month
❑Stelara®	❑45 mg/0.5 mL PFS (≤100kg)	❑1		❑Starter dose: Inject the contents of 1 prefilled Syringe Sub-Q initially Day 1
	❑90 mg/1 mL PFS (>100kg)	❑1		❑Maintenance dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter
❑Taltz®	❑80 mg/mL Autoinjector	❑Plaque Psoriasis (PP) 8 syringes		❑Starter dose: 160mg Sub-Q once, followed by 80mg at weeks 2, 4, 6, 8, 10, and 12
	❑80 mg/mL PFS	❑Plaque Psoriasis (PP) 1 syringe		❑Maintenance dose: 80mg Sub-Q every 4 weeks
		❑Psoriatic Arthritis (PsA) 2 syringes		❑Starter dose: 160mg Sub-Q once on day 1
		❑Psoriatic Arthritis (PsA) 1 syringe		❑Maintenance dose: 80mg Sub-Q every 4 weeks
❑Tremfya®		❑1 mL		❑100 mg Sub-Q at week 0, week 4, and every 8 weeks thereafter
❑Skyrizi®	❑75mg/0.83 mL PFS	❑2		❑Inject 150mg (2 syringes) at Weeks 0, 4, and then every 12 weeks thereafter

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.