REALO Rx SPECIALTY CARE PHARMACY

PEDIATRIC DERMATOLOGY PRESCRIPTION REFERRAL FORM

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 Address: ________

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

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® ❑PUVA
❑topical: ________

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL		DIRECTIONS
❑Dupixent® 6 to 17 years old	❑200mg ❑300mg	❑1 box PFS ❑1 box Pens		15kg to < 30kg	❑Starter pack: 600 mg once (administered as two 300 mg injections) ❑Maintenance dose: 300 mg Q4W
				30kg to < 60kg	❑Starter pack: 400 mg once (administered as two 200mg injections) ❑Maintenance dose: 200 mg Q2W
				≥ 60kg	❑Starter pack: 600 mg once (administered as two 300 mg injections) ❑Maintenance dose: 300 mg Q2W
❑Enbrel® 4 to 17 years old	❑25 mg/mL vial kit	❑1 kit (4x1 mL vials)			❑Inject 0.8 mg/kg once weekly (maximum dose 50mg)
❑Humira HS® ≥ 12 years old	❑40mg/0.4ml pen ❑40mg/0.4ml PFS	❑<60kg Starter Kit ❑1 box		30kg to < 60kg	❑Starter pack: Inject 80mg Sub-Q day 1, then 40mg one week later (day 8), then every other week thereafter ❑Maintenance dose: 40mg Sub-Q every other week
		❑≥60kg Starter Kit ❑2 boxes		≥ 60kg	❑Starter pack: Inject 160mg Sub-Q On day 1, then 80mg 2 weeks later (day 15), then 40 mg every week thereafter starting on day 29 ❑Maintenance dose: 40mg Sub-Q every week
❑Stelara® ≥ 12 years old	❑45mg/0.5mL vial	❑1 vial		< 60kg	❑Starter dose: Inject 0.75 mg/kg Sub-Q at week 0 and week 4, then every 12 weeks thereafter ❑Maintenance dose: Inject 0.75 mg/kg Sub-Q every 12
	❑45mg/0.5mL PFS	❑1		≥ 60kg to ≤ 100kg	❑Starter dose: Inject 45mg Sub-Q at week 0 and week 4, then every 12 weeks thereafter ❑Maintenance dose: Inject 45mg Sub-Q every 12 weeks
	❑90mg/1mL PFS	❑1		> 100kg	❑Starter dose: Inject 90mg Sub-Q at week 0 and week 4, then every 12 weeks thereafter ❑Maintenance dose: Inject 90mg Sub-Q every 12 weeks
❑Taltz® 6 to < 18 years old	❑80mg/mL autoinjector ❑80mg/mL PFS	❑1		< 25kg (Provider admin only – use PFS)	❑Starter dose: Inject 40mg Sub-Q at week 0, followed by 20mg every 4 weeks starting on week 4 ❑Maintenance dose: Inject 20mg Sub-Q every 4 weeks
				25kg to < 50kg (Provider admin only – use PFS)	❑Starter dose: Inject 80mg Sub-Q at week 0, followed by 40mg every 4 weeks starting on week 4 ❑Maintenance dose: Inject 40mg Sub-Q every 4 weeks
		❑2 ❑1		≥ 50kg	❑Starter dose: Inject 160 mg Sub-Q at week 0, followed by 80mg every 4 weeks starting on week 4 ❑Maintenance dose: Inject 80mg Sub-Q every 4 weeks

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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