DERMATOLOGY REFERRAL FORM

Date: _____ ☐ **Current Patient** ☐ **New Patient**

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home
☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____
ID#: _____ Group: _____
Secondary Insurance: _____
ID#: _____ Group: _____
Prescription Card: _____ ID#: _____
BIN: _____ PCN: _____ Group: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

Clinical Information (Please fax all pertinent clinical information)

Diagnosis: ☐ L20.9_____ (Atopic Dermatitis) ☐ L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) ☐ L40.8 (Other Psoriasis) ☐ L40.9 (Psoriasis, unspecified) ☐ L40.5 _____ (Psoriatic Arthritis) ☐ L73.2 (Hidradenitis Suppurativa) ☐ _____
Diagnosis Date: _____ **TB Test:** ☐ Yes ☐ No **Neg. Test Date**_____
HBV: ☐ Yes ☐ No If yes, currently treated: ☐ Yes ☐ No **Allergies:** _____
BSA affected (%): _____ **Affected areas:** ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐_____ **Prior Therapy:** ☐ Yes ☐ No
Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____ **Approximate End Date:** _____

Medication	Dose/Strength	Directions	Quantity	Refills
Cimzia	☐ 6 X 200 mg/mL (PFS Starter Kit) ☐ 2 X 200 mg/mL PFS ☐ 2 X 200 mg/mL Vial	☐ Inject 400mg sc at weeks 0, 2, and 4 ☐ Inject 200mg sc every 2 weeks ☐ Inject 400mg sc every 4 weeks ☐ For some patients <90 kg: Inject 400 mg sc at weeks 0, 2, and 4, then 200 mg every 2 weeks		
Cosentyx	☐ 300 mg Pen ☐ 150 mg Pen	☐ **Starter Dose**: Inject SC weeks 0, 1, 2, 3, and 4 ☐ **Maintenance**: Inject SC every 4 weeks		
Dupixent	☐ 300mg PFS	☐ **Starter dose:** Inject 300mg SC on day 1 and day 15 ☐ **Maintenance:** Inject 300mg SC every 2 weeks thereafter		
Enbrel	☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml SureClick Autoinjector ☐ 25mg/0.5ml Prefilled Syringe	☐ **Starter Dose:** Inject 50mg SC twice a week (72-96 hrs apart for 3 months) ☐ **Maintenance:** Inject SC every 4 weeks		
Humira	☐ 20mg/0.2mL Pen ☐ 40mg/0.4mL Pen ☐ 40mg/0.8mL Pen or Syringe ☐ 40mg Kit 4 X 0.8 ml ☐ 40mg Psoriasis Starter Pack	☐ **Starter Dose:** Inject 80mg SC on Day 1 ☐ **Maintenance:** Inject 50mg SC once weekly thereafter **Other**_____	☐ Initial Dose 1: Other: _____ ☐ Injection training required from My Humira	
Ilumya	☐ 100mg/1ml Prefilled Syringe	☐ **Starter Dose:** Inject 100mg SC 0, 4 ☐ **Maintenance:** 100mg SC every 12 weeks		
Orencia	☐ 125mg PFS ☐ 250mg/mL Vial ☐ 125mg ClickJect Pen	☐ **Starter Dose:** Infuse _____ mg at week 0, 2, and 4 ☐ **Maintenance** Infuse _____ mg at every 4 week thereafter (<60kg=500mg, 60 to 100kg=750mg, >100kg=1000mg)		
Otezla	☐ 30 mg	☐ 2 X Daily ☐ 28 Day Starter Pack		
Remicade / Renflexis / Inflectra	☐ 100 mg Vial	**Starter Dose:** ☐ 5mg/kg (dose _____mg) IV at 0.2 and 6 weeks, then every 8 weeks thereafter **Maintenence:** ☐ 5mg/kg (Dose ____ mg) IV every 8 weeks ☐ IV _____ mg every _____ weeks		
Siliq	☐ 210 mg/1.5ml PFS	☐ Inject 210mg SC at weeks 0, 1, and 2 and 210mg SC every 2 weeks thereafter	☐ Starter Dose (3 PFS) ☐ Maintenance Dose (2 PFS)	
Simponi/ Simponi Aria	☐ 100 mg/ml Autoinjector ☐ 100 mg/ml PFS ☐ 50mg/ml Autoinjector ☐ 50 mg/ml PFS ☐50 mg/4ml vial	☐ Inject 100 mg SC once a month ☐ Inject 50 mg SC once a month ☐ Infuse ___ mg (2mg/kg00 over 30 minutes at 0 and 4, then every 8 weeks)	☐ 4-wk supply ☐ Other: _____	
Skyrizi	☐75mg/0.83(150mg dose)	**Initial Dose:**☐ Inject 150 sc 0, 4 ☐ Inject 150mg every 12 weeks		
Stelara	☐ 45 mg/0.5 ml PFS ☐ 90 mg/1.0 ml PFS	**Starter Dose:** ☐ Inject 45mg SC (pt<100kg) on day 1 and day 28 for starter dose ☐ Inject 90mg SC (pt>100kg) on day 1 and day 28 for starter dose **Maintenance:** ☐ Inject 45 mg SC (pt<100kg) every 12 weeks thereafter. ☐ Inject 90 mg sc (pt>100kg) every 12 weeks thereafter	☐ Initial Dose 1 ☐ Other: _____	
Taltz	☐ 80 mg/ml Autoinjector	☐ **Starter Dose:** Inject 160mg SC at week 0 then 80mg 2, 4, 6, 8, 10, and 12 ☐ **Maintenance:** Inject 80mg SC every 4 weeks		
Tremfya	☐ Pre-filled syringe	☐ Inject 100 mg sq on week 0 and 4 (Qty 1 plus 1 refill) ☐ Inject 100 mg sq every 8 weeks (Qty 1)		
Xeljanz/XR	☐ 5 mg ☐ 11mg	☐ Take 5 mg po, bid ☐ Take 11 mg po once daily		

If Century Specialty Script is the patient's choice, please Call, Fax, Mail, or send an electronic prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353

Prescriber Signature: _____ **DAW (Dispense as Written) Date:** _____