

DERMATOLOGY REFERRAL FORM	Century Specialty Script Fax Referral To: 877-521-5353 Phone: 800-521-3949	
Date: _____		
<input type="checkbox"/> Current Patient <input type="checkbox"/> New Patient		

Need by date: _____ Ship to: Patient's home Prescriber 1st Order Only Prescriber All Orders

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Alternate Phone: _____	DEA: _____ NPI #: _____
DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

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

Clinical Information (please fax all pertinent clinical information)	
Diagnosis: <input type="checkbox"/> L20.9 (Atopic Dermatitis) <input type="checkbox"/> L40.0 (Psoriasis Vulgaris/Plaque Psoriasis/Nummular Psoriasis) <input type="checkbox"/> L40.8 (Other Psoriasis)	
<input type="checkbox"/> L40.9 (Psoriasis/Unspecified) <input type="checkbox"/> L40.5 (Psoriatic Arthritis) <input type="checkbox"/> L73.2 (Hidradenitis Suppurativa)	
<input type="checkbox"/> M33 (Dermatopolymyositis) <input type="checkbox"/> M33.1 (Dermatomyositis) <input type="checkbox"/> L12.9 (Pemphigoid/Pemphigus) <input type="checkbox"/> L10.0 (Pemphigus Vulgaris)	
Diagnosis Date: _____	Tb Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Neg. Text Date: _____
HBV: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Currently Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies: _____
BSA Affected (%): _____	Affected Areas: <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia <input type="checkbox"/> _____
Prior Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____	Approximate End Date: _____

Prescription Information				
Medication	Dose Strength	Directions	Qty	Refills
Cimzia	<input type="checkbox"/> 6 x 200mg/mL (PFS Starter Kit) <input type="checkbox"/> 2 x 200mg/mL PFS <input type="checkbox"/> 2 x 200mg/mL Vial	<input type="checkbox"/> Inject 400mg SC at weeks 0, 2 and 4 <input type="checkbox"/> Inject 200mg SC every 2 weeks <input type="checkbox"/> Inject 400mg SC every 4 weeks <input type="checkbox"/> For some patients <90kg: Inject 400mg SC at weeks 0, 2 and 4, then 200mg every 2 weeks		
Cosentyx	<input type="checkbox"/> 300mg Sensoready Pen <input type="checkbox"/> 150mg Sensoready Pen	<input type="checkbox"/> Starter Dose: Inject SC weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance Dose: Inject SC every 4 weeks		
Dupixent	<input type="checkbox"/> 300mg PFS <input type="checkbox"/> 200mg PFS	<input type="checkbox"/> Starter Dose: Inject 200mg SC on Day 1 and Day 15 <input type="checkbox"/> Starter Dose: Inject 300mg SC on Day 1 and Day 15 <input type="checkbox"/> Maintenance Dose: Inject 200mg SC every 2 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 300mg SC every 2 weeks thereafter		
Enbrel	<input type="checkbox"/> 50mg/mL Prefilled Syringe <input type="checkbox"/> 50mg/mL SureClick Autoinjector <input type="checkbox"/> 25mg/0.5mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 50mg SC twice a week (72-96 hours apart for 3 months) <input type="checkbox"/> Maintenance Dose: Inject SC every 4 weeks		
Humira	<input type="checkbox"/> 20mg/0.2mL Pen <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.8mL Pen or Syringe <input type="checkbox"/> 40mg Kit 4 x 0.8mL <input type="checkbox"/> 40mg Psoriasis Starter Pack	<input type="checkbox"/> Starter Dose: Inject 80mg SC on Day 1 <input type="checkbox"/> Maintenance Dose: Inject 40mg SC once weekly thereafter Other: _____	<input type="checkbox"/> Initial Dose 1: Other: _____ <input type="checkbox"/> Injection training required from my Humira	
Ilumya	<input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 100mg SC at weeks 0 and 4 <input type="checkbox"/> Maintenance Dose: 100mg SC every 12 weeks		

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

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

DERMATOLOGY REFERRAL FORM	Century Specialty Script Fax Referral To: 877-521-5353 Phone: 800-521-3949	
Date: _____		
<input type="checkbox"/> Current Patient <input type="checkbox"/> New Patient		

Need by date: _____ Ship to: Patient's home Prescriber 1st Order Only Prescriber All Orders

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Alternate Phone: _____	DEA: _____ NPI #: _____
DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

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

Clinical Information (please fax all pertinent clinical information)	
Diagnosis: <input type="checkbox"/> L20.9 (Atopic Dermatitis) <input type="checkbox"/> L40.0 (Psoriasis Vulgaris/Plaque Psoriasis/Nummular Psoriasis) <input type="checkbox"/> L40.8 (Other Psoriasis)	
<input type="checkbox"/> L40.9 (Psoriasis/Unspecified) <input type="checkbox"/> L40.5 (Psoriatic Arthritis) <input type="checkbox"/> L73.2 (Hidradenitis Suppurativa)	
<input type="checkbox"/> M33 (Dermatopolymyositis) <input type="checkbox"/> M33.1 (Dermatomyositis) <input type="checkbox"/> L12.9 (Pemphigoid/Pemphigus) <input type="checkbox"/> L10.0 (Pemphigus Vulgaris)	
Diagnosis Date: _____	Tb Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Neg. Text Date: _____
HBV: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Currently Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies: _____
BSA Affected (%): _____	Affected Areas: <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia <input type="checkbox"/> _____
Prior Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____	Approximate End Date: _____

Prescription Information				
Medication	Dose Strength	Directions	Qty	Refills
IVIG Orders		_____ mg/kg IV divided over _____ day(s) _____ mg/kg IV divided over _____ day(s) Frequency: <input type="checkbox"/> Every _____ weeks for one year <input type="checkbox"/> one time dose		
Orencia	<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 250mg/mL Vial <input type="checkbox"/> 125mg ClickJect Pen	<input type="checkbox"/> Starter Dose: Infuse _____ mg at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: Infuse _____ mg at every 4 weeks thereafter (<60kg = 500mg, 60kg to 100kg = 750mg, and >100kg = 1000mg) <input type="checkbox"/> SC: Inject 125mg SC once a week		
Otezla	<input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> 30mg	<input type="checkbox"/> Starter Pack: Take as Directed <input type="checkbox"/> Maintenance Dose: Take 1 Table BID		
<input type="checkbox"/> Remicade <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Starter Dose: 5mg/kg (dose _____ mg) IV at 0, 2, and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 5mg/kg (dose _____ mg) IV every 8 weeks IV _____ mg every _____ weeks		
Rituxan	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Loading Dose: 1000mg IV at Day 0 and Day 15 <input type="checkbox"/> Maintenance Dose: 50mg IV at month 12 and every 6 months thereafter		
Siliq	<input type="checkbox"/> 210mg/1.5mL PFS	<input type="checkbox"/> Loading Dose: Inject 210mg SC at weeks 0,1, and 4 <input type="checkbox"/> Maintenance Dose: 210mg SC every 2 weeks thereafter	<input type="checkbox"/> Starter Dose: 3 PFS <input type="checkbox"/> Maintenance Dose 2 PFS	

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

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

DERMATOLOGY REFERRAL FORM	Century Specialty Script Fax Referral To: 877-521-5353 Phone: 800-521-3949	
Date: _____		
<input type="checkbox"/> Current Patient <input type="checkbox"/> New Patient		

Need by date: _____ Ship to: Patient's home Prescriber 1st Order Only Prescriber All Orders

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Alternate Phone: _____	DEA: _____ NPI #: _____
DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

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

Clinical Information (please fax all pertinent clinical information)	
Diagnosis: <input type="checkbox"/> L20.9 (Atopic Dermatitis) <input type="checkbox"/> L40.0 (Psoriasis Vulgaris/Plaque Psoriasis/Nummular Psoriasis) <input type="checkbox"/> L40.8 (Other Psoriasis)	
<input type="checkbox"/> L40.9 (Psoriasis/Unspecified) <input type="checkbox"/> L40.5 (Psoriatic Arthritis) <input type="checkbox"/> L73.2 (Hidradenitis Suppurativa)	
<input type="checkbox"/> M33 (Dermatopolymyositis) <input type="checkbox"/> M33.1 (Dermatomyositis) <input type="checkbox"/> L12.9 (Pemphigoid/Pemphigus) <input type="checkbox"/> L10.0 (Pemphigus Vulgaris)	
Diagnosis Date: _____	Tb Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Neg. Text Date: _____
HBV: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Currently Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies: _____
BSA Affected (%): _____	Affected Areas: <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia <input type="checkbox"/> _____
Prior Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____	Approximate End Date: _____

Prescription Information				
Medication	Dose Strength	Directions	Qty	Refills
Simponi / Simponi Aria	<input type="checkbox"/> 100mg/mL Autoinjector <input type="checkbox"/> 100mg/mL PFS <input type="checkbox"/> 50mg/mL Autoinjector <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/4mL Vial	<input type="checkbox"/> Inject 100mg SC once a month <input type="checkbox"/> Inject 50mg SC once a month <input type="checkbox"/> Infuse _____ mg (2mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks)	<input type="checkbox"/> 4 week supply	
Skyrizi	<input type="checkbox"/> 75mg/0.83mL (150mg dose)	<input type="checkbox"/> Initial Dose: Inject 150mg SC weeks 0, and 4 <input type="checkbox"/> Maintenance Dose: Inject 150mg SC every 12 weeks		
Stelara	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/1.0mL PFS	Starter Dose: <input type="checkbox"/> Inject 45mg SC (pt<100kg) on Day 1 and Day 28 <input type="checkbox"/> Inject 90mg SC (pt>100kg) on Day 1 and Day 28 Maintenance Dose: <input type="checkbox"/> Inject 45mg SC (pt<100kg) every 12 weeks thereafter <input type="checkbox"/> Inject 90mg SC (pt>100kg) every 12 weeks thereafter	<input type="checkbox"/> Initial Dose: 1 other: _____	
Taltz	<input type="checkbox"/> 80mg/mL Autoinjector	<input type="checkbox"/> Starter Dose: Inject 160mg SC at week 0, then 80mg at weeks 2, 4, 6, 8, 10, and 12 weeks <input type="checkbox"/> Maintenance Dose: Inject 80mg SC every 4 weeks		
Tremfya	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Inject 100mg SC on weeks 0 and 4 <input type="checkbox"/> Inject 100mg SC every 8 weeks	<input type="checkbox"/> 1 Plus Refill <input type="checkbox"/> 1	
Xeljanz/XR		<input type="checkbox"/> Take 5mg PO BID <input type="checkbox"/> Take 11mg PO once daily		

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

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