CALIFORNIA SPECIALTY™ PHARMACY

DERMATOLOGY REFERRAL FORM

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Rep: ______________________ and Tel: ________________

PATIENT INFORMATION:	**PHYSICIAN INFORMATION:** Ship to: ☐Physician's Office ☐Patient's Home
Patient Name: ____________	Physician Name: ____________
Address: ____________	Address: ____________
City: ________ State: ______ Zip: ______	City: ________ State: ______ Zip: ______
Home Phone: ________ Alternate Phone: ________	Phone: ________ Fax: ________
Email: ____________	Office Email: ____________
Soc. Sec #: ________ Sex: ☐ Male ☐ Female	Key Office Contact ____________
Date of Birth: ________	State LIC # ________ NPI # ________ DEA# ________
Weight:______ ☐ lbs ☐Kg Height:______ ☐ ft ☐ cm BSA:______	

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10: ☐ Psoriasis /________________ ☐ Psoriatic Arthritis / ________________ ☐ Chronic Idiopathic Urticaria / ______________
☐ Hidradenitis Suppurativa / ________________ ☐ Other: ________________

PSO/PSA		
PSO/PSA	**Diagnosed with:** ☐ CHF ☐ Latex Allergy ☐ MS ☐ Hep B/C ☐ Malignancy	**Affected areas:** ☐ palms ☐ soles ☐ head ☐ neck ☐ genitalia
	TB/PPD test: Y / N Date of negative test:	**% of BSA affected:**
	☐ **Patient is currently on therapy (Start date ____________) Prior Therapies:** Please include biologics, MTX, PUVA, topicals, UVB/NBUVB and trials, including dates of treatment and reasons for discontinuation.	

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: ________________________________

MEDICATIONS & DIRECTIONS

	PRESCRIPTION	QUANTITY		REFILL
☐ **Cimzia®** **(certolizumab)**	☐ Inject 400 mg subcut at weeks 0, 2 and 4	☐ 6 X 200 mg/mL	☐ PFS Starter Kit ☐ Vials	0
	☐ Inject 400 mg subcut every 2 weeks	☐ 4 X 200 mg/mL	☐ PFS ☐ Vials	_____
	☐ Inject 200 mg subcut every 2 weeks	☐ 2 X 200 mg/mL		
	☐ Inject 400 mg subcut every 4 weeks	☐ 2 X 200 mg/mL		
☐ **Cosentyx®** **(secuklnumab)**	☐ Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3	☐ 4 X 150 mg/mL	☐ Sensoready® Pen ☐ PFS	0
	☐ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	☐ 8 X 150 mg/mL		
	☐ Inject 150 mg subcut on week 4 and every 4 weeks thereafter	☐ 1 X 150 mg/mL	☐ Sensoready® Pen ☐ PFS	_____
	☐ Inject 300 mg subcut on week 4 and every 4 weeks thereafter	☐ 2 X 150 mg/mL		
☐ **Dupixent**	☐ **≥6 months and Children <6 years** ☐ Inject 200 mg subcut every 4 weeks if 5 to <15 kg ☐ Inject 300 mg subcut every 4 weeks if 15 to <30 kg	☐ 2 x 200 mg/1.14 mL (56 day supply) ☐ 2 x 300 mg/2 mL (56 day supply)	☐ PFS	0
	☐ **Children ≥6 years and Adolescents ≤17 years** ☐ **PFS ≥6 years; Pen ≥12 years** ☐ **15 to <30 kg** ☐ Inject 600 mg subcut on day 1 ☐ Inject 300 mg subcut every 4 weeks ☐ **30 to <60 kg** ☐ Inject 400 mg subcut on day 1 ☐ Inject 200 mg subcut every 2 weeks ☐ **≥60 kg:** ☐ Inject 600 mg subcut on day 1 ☐ Inject 300 mg subcut every other week	☐ 2 x 300 mg/2 mL ☐ 2 x 200 mg/1.14 mL ☐ 2 x 300 mg/2 mL ☐ 2 x 300 mg/2 mL	☐ PFS	0
☐ **Enbrel®** **(etanercept)** Adult	☐ Inject 50 mg subcut twice a week (72-96 hours apart) for 3 months	☐ 8 X 50 mg/mL	☐SureClick ® Autoinjector ☐Mini™ Cartridge ☐PFS	2
	☐ Inject 50 mg subcut every week	☐ 4 X 50 mg/mL		_____
☐ **Humira®** **(adalimumab)**	☐ **Plaque Psoriasis (Adult) OR Hidradenitis Suppurativa (Adolescents 12 yrs and older (30 kg to < 60 kg) Starter Dose:** Inject 80 mg subcut day 1, then 40 mg on day 8, then 40mg every 2 weeks thereafter	☐ 1 X 80 mg/0.8 mL + 2 X 40 mg/0.4 mL **CF**	Starter Kit Pens	0
		☐ 4 X 40 mg/0.8 mL	Starter Kit Pens	
		☐ 4 X 40 mg/0.4 mL **CF**	☐ PFS ☐ Pens	
	☐ **Plaque Psoriasis (Adult) OR Hidradenitis Suppurativa (Adolescents 12 yrs and older (30 kg to < 60 kg) Maintenance:** Inject 40 mg subcut every 2 weeks	☐ 2 X 40 mg/0.4 mL **CF**	☐ PFS ☐ Pens	_____
		☐ 2 X 40 mg/0.8 mL		
	☐ **Hidradenitis Suppurativa (Adult) OR Adolescents 12 yrs and older (≥ 60 kg) Starter Dose**: Inject 160mg subcut on day 1, 80 mg on day 15, then 40 mg on day 29 and once weekly thereafter	☐ 3 X 80 mg/0.8 mL **CF**	Starter Kit Pens	0
	☐ **Hidradenitis Suppurativa (Adult) OR Adolescents 12 yrs and older (≥ 60 kg) Maintenance:** Inject 40mg subcut on day 29 and once weekly thereafter	☐ 4 X 40 mg/0.4 mL **CF**	☐ PFS ☐ Pens	_____
		☐ 4 X 40 mg/0.8 mL		
☐ **Skyrizi™** **(risankizumab-rzaa)**	☐ Inject 150 mg (1 mL) subcut at week 0,4 every 12 weeks thereafter.	☐ 2 x 150 mg/1mL	☐ PFS ☐ Autoinjector	_____
	☐ Add: Inject 150 mg (1 mL) subcut every 12 weeks	☐ 1 x150 mg/mL	☐ PFS ☐ Autoinjector	_____
☐ **Orencia®** **(abatacept)** Psoriatic Arthritis	☐ Infuse ________ mg at week 0 and 2	☐ 28 day supply	SDV	0
	☐ Infuse ________ mg at week 4 and every 4 weeks thereafter <60 kg = 500 mg, 60 to 100 kg = 750 mg, > 100 kg = 1000 mg	☐ 28 day supply	SDV	_____

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	☐ Inject 125 mg subcut once weekly	☐ 4 X 250 mg/mL	☐ PFS ☐ Autoinjector	
☐ **Otezla®** **(apremilast)**	☐ Take as directed per package instructions	☐ 55 tablets	28 day starter pack	0
	☐ Take 30 mg by mouth twice daily	☐ 60 X 30 mg	Tablets	_____
☐ **Stelara®** **(ustekinumab)** Adult	☐ Inject 45 mg subcut on Day 1 (≤ 100 kg) ☐ Inject 90 mg subcut on Day 1 (> 100 kg)	☐ 1 X 45 MG /0.5 mL ☐ 1 X 90 MG/1 mL	PFS	0
	☐ Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤ 100 kg) ☐ Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (> 100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 X 90 MG/1 mL	PFS	_____
☐ **Tremfya®** **(guselkumab)**	☐ Inject 100 mg subcut at week 0	☐ 1 X 100 mg/ml	PFS	0
	☐ Inject 100 mg subcut at week 4 and every 8 weeks thereafter	☐ 1 X 100 mg/mL	PFS	_____
☐ **Xeljanz®** **(tofacitinib)**	Take 5 mg by mouth twice daily	☐ 60 X 5 mg	Tablets	_____
☐ **Xeljanz® XR** **(tofacitinib)**	Take 11 mg by mouth once daily	☐ 30 X 11mg	Tablets	_____

Prescriber Signature Required		****Prescription is void if the number of drugs prescribed is not noted***
I authorize California Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.		
PRESCRIBER SIGNATURE	**DATE**	**NO. OF DRUGS PRESCRIBED _______** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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