US Bioservices
AmerisourceBergen

Dermatology Referral Form

Phone: (888) 518-7246
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Last Name: _____ Home Phone:_____ Work/Mobile Phone:_____

First Name: _____ Home Address:_____

S.S. #:_____ Date of Birth:_____ City:_____ State:_____ Zip:_____

Guardian/Caregiver:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:_____ Phone:_____ Prescription Card: _____ Phone:_____

Subscriber Name:_____ Policy #:_____ BIN/PCN:_____

Policy #:_____ Group #:_____ Medicare #:_____ Medicaid #:_____

3. Prescriber Information

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA License #:_____ NPI #:_____ DEA #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____ Phone:_____

City: _____ State:_____ Zip:_____ Collaborating Physician:_____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10:_____ Secondary ICD-10:_____ Meds Tried & Failed:_____

Allergies:_____ Concurrent Medications:_____

Vaccination History:_____ _____

5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
COSENTYX®	☐ 150 mg/mL PFS ☐ 150 mg/mL Sensoready® Pen	☐ Initial dose: Inject 300 mg SC at weeks 0, 1, 2, 3, & 4	5	0
		☐ Maintenance dose: Inject 300 mg SC Q4wks	1	
CIMZIA®	☐ 200 mg Starter Kit ☐ 200 mg PFS Kit ☐ 200 mg Vial Kit	☐ Initial dose: Inject 400 mg SC QW at weeks 0, 2, & 4		
		☐ Maintenance dose: Inject 400 mg SC Q4wks ☐ Maintenance dose: Inject 200 mg SC Q4wks		
DUPIXENT®	☐ 300 mg/2 mL PFS	☐ Initial dose: Inject 600 mg SC (divided in two different injection sites)	2	0
		☐ Maintenance dose: Inject 300 mg SC every other week	1	
ENBREL®	☐ 25 mg PFS ☐ 50 mg PFS ☐ 25 mg Vial ☐ 50 mg Sureclick Autoinjector	☐ Inject 50 mg SC BIW for 3 months followed by 50 mg QW ☐ Inject 50 mg SC QW		
HUMIRA®	☐ Psoriasis/Uveitis Starter Pack (4x40 mg/0.8 mL Pens)	• Day 1: Inject 80 mg SC x 1 dose • Day 8 and after: Inject 40 mg SC	1 Kit	
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS	• Inject 40 mg SC every other week	1 Kit	
ILUMYA™	☐ 100 mg/mL PFS	☐ Initial dose: Inject 100 mg SC at week 0 & 4	2	0
		☐ Maintenance dose: Inject 100 mg SC Q12wks	1	
OTEZLA®	☐ 28 Day Starter Pack	• Day 1: Take 10 mg PO QAM • Day 2: Take 10 mg PO BID • Day 3: Take 10 mg PO QAM & 20 mg QPM • Day 4: Take 20 mg PO BID • Day 5: Take 20 mg PO QAM & 30 mg QPM • Day 6: Take 30 mg PO BID		
	☐ Maintenance dose: 30 mg	• Take 30 mg PO BID	1 Pack	
SIMPONI®	☐ 50 mg/0.5 mL PFS ☐ 50 mg/0.5 mL Autoinjector	• Inject 50 mg SC once a month	1	
SKYRIZI™	☐ 75 mg/0.83 mL PFS	• Inject 150 mg (two 75 mg injections) SC at weeks 0 and 4, then 150 mg Q12wks	1 Carton	
STELARA®	☐ 45 mg/0.5 mL PFS ☐ 90 mg/1mL PFS	☐ **(≤100kg (220 lbs):** Inject 45 mg SC at weeks 0 and 4, then 45 mg Q12wks		
		☐ **(>100kg (220 lbs):** Inject 90 mg SC at weeks 0 and 4, then 90 mg Q12wks		
TALTZ®	☐ 80 mg PFS ☐ 80 mg Autoinjector	☐ Initial dose: Inject 160 mg SC at week 0, followed by 80 mg at weeks 2 & 4	4	0
		☐ Initial dose: Inject 80 mg SC at weeks 6, 8, 10 & 12	2	1
		☐ Maintenance dose: Inject 80 mg SC Q4wks	1	
TREMFYA®	☐ 100 mg PFS	☐ Initial dose: Inject 100 mg SC at week 0 & 4	2	0
		☐ Maintenance dose: Inject 100 mg SC Q8wks	1	

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date _____ / _____ / _____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____