US Bioservices
AmerisourceBergen

Dermatology Referral Form (A-I)

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: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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
CIMZIA®	☐ 200 mg Starter Kit	☐ Initial dose: Inject 400 mg SC qw at weeks 0, 2 and 4	1	0
	☐ 200 mg PFS Kit ☐ 200 mg LYO SDV Kit	☐ Maintenance dose: ≤ 90 kg (198 lb): Inject 200 mg SC q4weeks ☐ Maintenance dose: Inject 400 mg SC q4weeks		
COSENTYX®	☐ 150 mg/mL PFS ☐ 150 mg/mL Sensoready® Pen	☐ Initial dose: Inject 300 mg SC at weeks 0, 1, 2, 3 and 4	5	0
		☐ Maintenance dose: Inject 300 mg SC q4weeks	1	0
DUPIXENT®	☐ 200 mg/1.14mL PFS ☐ 300 mg/2 mL 2-PFS ☐ 300 mg/2mL 2-PFP	☐ Initial dose: Inject 600 mg SC (two different injection sites), then 300 mg SC every other week	2	
		☐ Maintenance dose: Inject 200 mg SC every other week ☐ Maintenance dose: Inject 300 mg SC every other week ☐ Maintenance dose: Inject 300 mg SC q4weeks	1	0
ENBREL®	☐ 50 mg PFS ☐ 50 mg Sureclick® Autoinjector	☐ Initial dose: Inject 50 mg SC BIW for 3 months ☐ Maintenance dose: Inject 50 mg SC qweek		
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 every other week	1 Kit	0
	☐ 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 Box	
ILUMYA™	☐ 100 mg/mL PFS	☐ Initial dose: Inject 100 mg SC at week 0 and 4	2	
		☐ Maintenance dose: Inject 100 mg SC q12weeks	1	
Other:				

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 ____ / ____ / ____

US Bioservices
AmerisourceBergen

Dermatology Referral Form (O-Z)

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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: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 #: _____

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4. Diagnosis and 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
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 and 20 mg QPM • Day 4: Take 20 mg PO BID • Day 5: Take 20 mg PO QAM and 30 mg QPM • Day 6: Take 30 mg PO BID	1	0
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	☐ Initial dose: Inject 150 mg (two 75 mg injections) SC at weeks 0 and 4	1 Box	1
		☐ Maintenance dose: Inject 150 mg (two 75 mg injections) SC q12weeks	1 Box	
STELARA®	☐ 45 mg/0.5 mL PFS	☐ Initial dose: Inject 45 mg SC at weeks 0 and 4	2	0
		☐ Maintenance dose: Inject 45 mg SC q12weeks	1	
	☐ 90 mg/1mL PFS	☐ Initial dose: Inject 90 mg SC at weeks 0 and 4	2	
		☐ Maintenance dose: Inject 90 mg SC q12weeks	1	0
TALTZ®	☐ 80 mg PFS ☐ 80 mg Autoinjector	☐ Initial dose: Inject 160 mg SC at week 0, followed by 80 mg at weeks 2 and 4	4	0
		☐ Initial dose: Inject 80 mg SC at weeks 6, 8, 10 and 12	2	1
		☐ Maintenance dose: Inject 80 mg SC q4weeks	1	
TREMFYA®	☐ 100 mg PFS	☐ Initial dose: Inject 100 mg SC at week 0 and 4	2	0
		☐ Maintenance dose: Inject 100 mg SC q8weeks	1	
Other:				

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Account Manager

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

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