Dermatology
Referral Form

Please fax completed form to:
Fax: 386-385-7871
Phone 386-456-3000
AccordSpecialty@gmail.com

Ship To/Site of Care: ☐ In Office ☐ At Home ☐ Other (list):

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescriber Name:			
Address:				Address:			
City, State, Zip:				City, State, Zip:			
Phone:		Weight (kg)		NPI AND License:			
Alt Phone:		Gender:		Office Contact:		Email:	
DOB:		SSN:		Px:		Fax:	

CLINICAL INFORMATION

Allergies: ☐ NKDA ☐ Allergies:

Diagnosis: ICD-10: | Condition: | Date of Diagnosis:

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
☐ Benlysta	☐ 120 mg SDV	☐ Infuse 10 mg/kg IV over 1 hour every 2 weeks for 3 doses		
	☐ 400 mg SDV	☐ MAINTENANCE: Infuse 10 mg/kg IV over 1 hour every 4 weeks		
	☐ 200 mg/mL Circle: Pen PFS	☐ MAINTENANCE: Inject 200 mg SC once weekly		
☐ Cimzia	☐ Starter Kit	☐ INITIAL: Inject 400 mg SC at weeks 0, 2, and 4.	6	0
	☐ 200 mg PFS	☐ MAINTENANCE: Inject 200 mg SC every 2 weeks		
	☐ 200 mg SDV (2)	☐ MAINTENANCE: Inject 400 mg SC every 2 weeks		
☐ Ilumya	100 mg/ mL PFS	☐ Inject 100 mg SC at weeks 0, 4, and then every 12 weeks thereafter.		
		☐ MAINTENANCE: Inject 100 mg SC every 12 weeks.		
☐ Infliximab (Avsola, Inflectra, Remicade, Renflexis).	☐ 100 mg SDV	☐ INITIAL: Infuse 5 mg/kg IV over 2 hours at weeks 0, 2, and 6.		
		☐ MAINTENANCE: Infuse _____ mg/kg IV every _____ weeks		
	☐ Choice of brand per payer	☐ Do not auto-substitute. Brand Preferred:		
☐ Rituximab (Riabni, Rituxan, Ruxience, Truxima)	☐ 100 mg/10 mL	☐ INITIAL: Infuse 1 g IV at weeks 0, 2.		
	☐ 500 mg/50 mL	☐ Infuse _____ mg IV every _____ for _____ doses		
	☐ Choice of brand per payer	☐ Do not auto-substitute. Brand Preferred:		
☐ Skyrizi	☐ 150 mg/ mL Pen	☐ Inject 150 mg SC at weeks 0, 4, and then every 12 weeks thereafter.		
	☐ 150 mg/ mL PFS	☐ MAINTENANCE: Inject 150 mg SC every 12 weeks.		
☐ Stelara	☐ 45 mg PFS	☐ Inject 45 mg SC at 0 and 4 weeks, and then every 12 weeks thereafter.		
		☐ MAINTENANCE: Inject 45 mg SC every _____ weeks		
	☐ 90 mg/mL PFS	☐ Inject 90 mg SC at 0 & 4 weeks, and then every 12 weeks thereafter.		
		☐ MAINTENANCE: Inject 90 mg SC every _____ weeks.		
☐ Tremfya	☐ 100 mg/ mL Circle: Pen PFS	☐ Inject 100 mg SC at weeks 0, 4, and then every 8 weeks thereafter.		
		☐ MAINTENANCE: Inject 100 mg SC every 8 weeks.		
☐ Xolair	☐ 150 mg/mL	☐ Inject 300 mg SC every 4 weeks		
	☐ 300 mg/2mL	☐ Inject 150 mg SC every 4 weeks.		
	Circle: Pen PFS	☐ Inject _____ mg SC every _____ weeks.		
☐ Other (list)				

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

PRESCRIBER SIGNATURE

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Accord Specialty to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed. I understand that I can revoke this designation by providing notice to Accord.

Prescriber's Signature: _____ Date: _____