DERMATOLOGY REFERRAL FORM

Email: info@benevaspecialty.com
Fax: 805.371.0701
Phone: 805.371.0700

Beneva Specialty Pharmacy
375 Rolling Oaks Dr., Suite 150
Thousand Oaks, CA 91361
NPI: 1316428808

Beneva SPECIALTY PHARMACY

Ship to: ☐ Patient ☐ Prescriber ☐ Other _____

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Allergies: _____ ☐ NKDA
Phone: _____ Alternate Phone: _____
Email: _____ Preferred Contact: ☐ Phone ☐ Email
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax a copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Diagnosis: _____ Needs By: _____

☐ L20.9 Atopic Dermatitis
☐ L40.0 Plaque Psoriasis (moderate to severe)
☐ L40.9 Psoriasis
☐ L40.52 Psoriatic Arthritis
☐ L73.2 Hidradenitis Suppurativa
☐ L40.50 Arthropathic Psoriasis, unspecified
☐ L40.59 Other Psoriatic Arthropathy
☐ Other ICD10: _____

BSA: _____ **Weight:** _____ lb/kg **Height:** _____ in/cm
TB Result: _____ **Date:** _____

Treatment Status: ☐ New to therapy ☐ Continuation of therapy (date of last TX: _____)

Therapy Tried and Failed (please list medication and duration): _____
Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side effects ☐ Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ **Bimzelx**	☐ 160 mg PFS ☐ 160 mg Autoinjector	☐ **Initial Dose:** Inject 320 mg (2x160 mg injections) SQ at weeks 0, 4, 8, 12, and 16 ☐ **Maintenance Dose:** Inject 320 mg SQ every 8 weeks ☐ **Patients weighing ≥ 120kg:** Inject 320 mg SQ every 4 weeks	2 2 2	4 _____ _____
☐ **Cosentyx**	☐ 150 mg/mL PFS ☐ 150 mg/mL Sensoready Pen ☐ 150 mg/mL (2 Pack) Sensoready Pen ☐ 150 mg/mL (2-Pack) PFS ☐ 300 mg/2mL PFS ☐ 300 mg/2mL UnoReady Pen	☐ **Initial Dose:** Inject ☐ 150 mg ☐ 300 mg SQ weekly at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject ☐ 150 mg ☐ 300 mg SQ every 4 weeks	5 week supply 28 days	None _____
☐ **Cimzia**	☐ 200 mg/1mL Starter Kit ☐ 200 mg/1mL PFS	☐ **Initial Dose:** Inject 400 mg SQ initially: repeat dose on weeks 2 and 4 **For Psoriatic Arthritis** ☐ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks **For Plaque Psoriasis** ☐ **Maintenance Dose:** Inject 400 mg SQ every other week ☐ **Alternative Maintenance Dose for Patients <90kg:** Inject 400 mg SQ every 4 weeks.	6 SYR 2SYR 4SYR 2SYR	None _____ _____ _____
☐ **Dupixent** *(18+ years old)*	☐ 300 mg/2mL PFS ☐ 300 mg/2mL Prefilled PEN	☐ **Initial Dose:** Inject 600 mg SQ on day 1 (divided in 2 different injection sites) ☐ **Maintenance Dose:** Inject 300 mg SQ every 2 weeks starting day 15	2 2	None _____
☐ **Enbrel**	☐ 50 mg/mL PFS ☐ 50 mg/mL SureClick Autoinjector ☐ 50 mg/mL Mini-Cartridge	**For Psoriasis** ☐ **Initial Dose:** Inject 50 mg SQ twice a week for 3 months ☐ **Maintenance Dose:** Inject 50 mg SQ weekly **For Psoriatic Arthritis** ☐ Inject 50 mg SQ weekly	28 days 28 days 28 days	2 _____ _____

Referral form continued on next page

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☐ **Humira**	**For Psoriasis** ☐ Citrate-Free Psoriasis Starter Pack (80mg/0.8mL x1pen, 40 mg/0.4mL x2pens) ☐ Citrate-Free 40 mg/0.4mL PEN ☐ Citrate-Free 40 mg/0.4mL PFS	☐ **Initial Dose:** Inject 80 mg SQ once on day 1, then 40 mg on Day 8, then 40 mg every other week ☐ **Maintenance Dose:** Inject 40 mg SQ every other week	Loading dose 28 days	None _____
	For Hidradenitis Suppurativa (HS) ☐ Citrate-Free HS Starter Pack (80mg/0.8mL x3pens) ☐ Citrate-Free 40 mg/0.4mL PEN ☐ Citrate-Free 40 mg/0.4mL PFS	☐ **Initial Dose:** Inject 160 mg (given on 1 day or over 2 consecutive days) then 80 mg on day 15 ☐ **Maintenance Dose:** Inject 40 mg SQ every week starting day 29 ☐ **Alternate Maintenance Dose:** Citrate Free 80 mg/0.8mL Pen Inject 80 mg SQ every other week	Loading dose 28 days 28 days	None _____ _____
☐ **Opzelura**	1.5% Cream	Apply a thin layer to the affected area(s) twice daily	60gm	_____
☐ **Otezla**	☐ Titration Starter Pack ☐ 30 mg Tablet	☐ **Titration:** Take as directed per package instructions ☐ **Maintenance Dose:** Take 30 mg tablet by mouth twice a day every morning and evening	1 Pack 60 tablets	None _____
☐ **Rinvoq**	☐ 15 mg ER Tablet ☐ 30 mg ER Tablet	**For Atopic Dermatitis** **For patients ≥ 12 years weighing at least 40kg and adults <65 years old:** ☐ Take 15 mg ER tablet by mouth once daily ☐ Take 30 mg ER tablet by mouth once daily (if adequate response not achieved) **For patients ≥ 65 years old:** ☐ Take 15 mg ER tablet by mouth once daily	 30 tablets 30 tablets 30 tablets	 _____ _____ _____
☐ **Simponi**	☐ 50 mg/0.5mL Smartject Autoinjector ☐ 50 mg/0.5mL PFS	☐ Inject 50 mg SQ once per month	28 days	_____
☐ **Skyrizi**	☐ 150 mg/mL PFS ☐ 150 mg/mL Prefilled PEN	☐ **Initial Dose:** Inject 150 mg SQ at week 0 and week 4 ☐ **Maintenance Dose:** Inject 150 mg SQ every 12 weeks	QS QS	1 _____
☐ **Stelara**	☐ 45 mg/0.5mL PFS ☐ 90 mg/mL PFS	**For patients weighing ≤ 100kg (220lbs):** ☐ **Initial Dose:** Inject 45 mg SQ on day 0 and then week 4 ☐ **Maintenance Dose:** Inject 45 mg SQ every 12 weeks **For patients weighing ≥ 100kg (220lbs):** ☐ **Initial Dose:** Inject 90 mg SQ on day 0 and then week 4 ☐ **Maintenance Dose:** Inject 90 mg SQ every 12 weeks	 1 PFS 1 PFS 1 PFS 1 PFS	 1 _____ 1 _____
☐ **Taltz**	☐ 80 mg/1mL Autoinjector ☐ 80 mg/1mL PFS	**For Psoriasis** ☐ **Initial Dose:** Inject 90 mg SQ on day 1, then 80 mg at week 2; Then inject 80 mg at week 4, 6, 8, and 10; Then inject 80mg at week 12 **For Psoriatic Arthritis** ☐ **Initial Dose:** Inject 160 mg SQ at week 0 **For Psoriasis and Psoriatic Arthritis** ☐ **Maintenance Dose:** Inject 80 mg SQ every 4 weeks after initial dose	 3 2 1 2 1	 None 1 None None _____

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☐ **Tremfya**	☐ 100 mg/mL Single-dose PFS ☐ 100mg/mL Autoinjection	☐ **Initial Dose:** Inject 100 mg SQ at week 0 and on week 4 ☐ **Maintenance Dose:** Inject 100 mg SQ every 8 weeks	1 1	1 _____
☐ **Xeljanz** ☐ **Xeljanz XR**	☐ 5 mg Tablet ☐ 11 mg Tablet	☐ Take 1 tablet by mouth twice a day every morning and evening ☐ Take 1 tablet by mouth once a day	60 tablets 30 tablets	_____ _____
☐ **Zoryve**	0.3% Cream	**For Plaque Psoriasis** Apply to affected area once daily	60gm	_____
☐ **Zoryve**	0.3% Foam	**For Seborrheic Dermatitis** Apply to affected area once daily	60gm	_____
☐ Other (drug and strength): _____		_____	_____	_____
☐ Other (drug and strength): _____		_____	_____	_____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone:_____

PRESCRIBER SIGNATURE (DO NOT STAMP)

"Dispense as Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May No Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ Date: _____	Prescriber's Signature: _____ Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Beneva Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.

End of Referral Form