Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Dermatology Referral Form

1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400/ 479-464-8838

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):______________________ Date Needed:______________________ ❑Need Nurse ❑Need Training

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name:			Prescriber Name:		
Address:			NPI#:	DEA#	
City:	State:	Zip:	Address:		
Phone: ( )	Alt Phone: ( )		City:	State:	Zip:
Patient Soc. Sec#:	Date of Birth: / /		Phone: ( )	Fax: ( )	
Sex: ❑ Male ❑Female	Weight lbs/kg	Height	Nurse/Key Office Contact:		
Allergies:			Tax ID#		

CLINICAL INFORMATION ***(Please FAX recent clinical notes, labs, tests & current medication list with prescription)***

Diagnosis

❑ L20.____ Atopic Dermatitis ❑ L40.0 Psoriasis vulgaris ❑ L40.8 Other psoriasis ❑ L40.9 Psoriasis, unspecified ❑ L40.5 Psoriatic arthritis ❑ L63.______ Alopecia areata
❑ L73.2 Hidradenitis suppurativa Hurley Stage: _____________ ❑Other___________________

PRESCRIPTION

DRUG	DIRECTIONS	QUANTITY	DOSAGE FORM	REFILLS
Cibinqo™	❑ Take 1 tablet by mouth once daily.	❑ 30 tablets	❑ 100mg tablet ❑ 200mg tablet	
Cimzia®	❑ Inject 400mg SC at weeks 0, 2 & 4. **OR** ❑ Inject 400mg SC every 2 weeks.	❑ 6 x 200mg/mL	❑ Syringe Starter Kit	0
	❑ Inject 200mg SC every 2 weeks. **OR** ❑ Inject 400MG SC every 4 weeks.	❑ 2 x 200mg/mL	❑ Syringe	
Cosentyx®	❑ Inject 300mg SC at weeks 0, 1, 2 and 3 ❑ Inject 150mg SC at weeks 0, 1, 2 and 3	❑ 8 x 150mg/mL ❑ 4 x 150mg/mL	❑ Sensoready® Pen ❑ Syringe	0 0
	❑ Inject 300mg SC at week 4, then every 4 weeks thereafter. ❑ Inject 150mg SC at week 4, then every 4 weeks thereafter.	❑ 2 x 150mg/mL ❑ 1 x 150mg/mL	❑ Sensoready® Pen ❑ Syringe	
Dupixent®	❑ Inject 600mg SC on day 1, then 300mg at day 15 and every 2 weeks thereafter.	❑ 2 x 300mg/2mL	❑ Syringe ❑ Pen	0
	❑ Inject 300mg SC at day 15 and every 2 weeks thereafter.	❑ 2 x 300mg/2mL	❑ Syringe ❑ Pen	
Enbrel ® *Adult*	❑ Inject 50mg SC twice weekly.	❑ 8 x 50mg/mL	❑ Sureclick® Autoinjector ❑ Mini™ Cartridge ❑ Syringe	
	❑ Inject 50mg SC once weekly.	❑ 4 x 50mg/mL		
Humira® *Adult*	❑ <u>Psoriasis Starter</u>: Inject 80mg SC Day 1, then 40mg on Day 8, then 40mg every OTHER week thereafter.	❑ 1 x 80mg/0.8mL & 2 x 40mg/0.4mL**CF** ❑ 4 x 40mg/0.8mL	❑ Starter Kit Pens	0
	❑ <u>Maintenance</u>: Inject 40mg SC every OTHER week.	❑ 2 x 40mg/0.4mL **CF** ❑ 2 x 40mg/0.8mL	❑ Syringe ❑ Pen	
	❑ <u>Hidradenitis Suppurativa Starter:</u> Inject 160mg SC Day 1, then 80mg on Day 15. **OR** ❑ Inject 80mg SC Day 1, 80mg Day 2, then 80mg Day 15.	❑ 3 x 80mg/0.8mL **CF** ❑ 6 x 40mg/0.8mL	❑ Starter Kit Pens ❑ Syringe ❑ Pen	0 0
	❑ <u>Hidradenitis Suppurativa Maintenance</u>: Inject 40mg SC on day 29 and once weekly thereafter. **OR** ❑ Inject 80mg SC on day 29 and once every OTHER week thereafter.	❑ 4 x 40mg/0.4mL **CF** ❑ 4 x 40mg/0.8mL ❑ 2 x 80mg/0.8mL **CF**	❑ Syringe ❑ Pen ❑ Syringe ❑ Pen ❑ Pen	
Ilumya™	❑ Inject 100mg SC at week 0,4 and every 12 weeks thereafter.	❑ 1 x 100mg/1mL	❑ Syringe	
Olumiant®	❑ Take 1 tablet by mouth once daily.	❑ 30 tablets	❑ 2mg tablet ❑ 4mg tablet	
Otezla®	❑ Take as directed by mouth per package instructions.	❑ 55 tablets	❑ Starter pack 28 day	0
	❑ Take 1 tablet (30mg) by mouth twice daily.	❑ 60 tablets	❑ 30mg tablet	
Rinvoq®	❑ Take 1 tablet by mouth once daily.	❑ 30 tablets	❑ 15mg ER tablet ❑ 30mg ER tablet	
Siliq™	❑ Inject 210mg SC once weekly at weeks 0,1 and 2, then 210mg every 2 weeks.	❑ 4 x 210mg/1.5mL	❑ Syringe	0
	❑ Inject 210mg SC every 2 weeks.	❑ 2 x 210mg/1.5mL	❑ Syringe	
Skyrizi™	❑ Inject 150mg SC at week 0.	❑ 1 x 150mg/mL	❑ Syringe ❑ Pen	0
	❑ Inject 150mg SC at week 4, then every 12 weeks thereafter.	❑ 1 x 150mg/mL	❑ Syringe ❑ Pen	
Sotyktu®	❑ Take 1 tablet by mouth once daily.	❑ 30 tablets	❑ 6mg tablet	
Stelara® *Adult*	❑ **≤ 100kg:** Inject 45mg SC on day 1. ❑ **≤ 100kg:** Inject 45mg SC on day 29 & every 12 weeks thereafter.	❑ 1 x 45mg/0.5mL ❑ 1 x 45mg/0.5mL	Syringe Syringe	0 _____
	❑ **>100kg:** Inject 90mg SC at day 1. ❑ **>100kg:** Inject 90mg SC on day 29 & every 12 weeks thereafter.	❑ 1 x 90mg/mL ❑ 1 x 90mg/mL	Syringe Syringe	0 _____
Taltz®	❑ Inject 160mg (2 x 80mg) SC at week 0, then 80mg SC at week 2.	❑ 3 x 80mg/mL	❑ Syringe ❑ Autoinjector	0
	❑ Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10.	❑ 2 x 80mg/mL	❑ Syringe ❑ Autoinjector	1
	❑ Inject 80mg SC at week 12 and every 4 weeks thereafter.	❑ 1 x 80mg/mL	❑ Syringe ❑ Autoinjector	
Tremfya™	❑ Inject 100mg SC at week 0.	❑ 1 x 100mg/mL	❑ Syringe ❑ Pen	0
	❑ Inject 100mg SC at week 4 and every 8 weeks thereafter.	❑ 1 x 100mg/mL	❑ Syringe ❑ Pen	

<u>To Prescriber</u>: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.*

Date: ______________________ ______________________________________ ______________________________________

DISPENSE AS WRITTEN **MAY SUBSTITUTE**