PUBLIX PHARMACY

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Dermatology Referral Form

Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/_____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis code(s): _____ Diagnosis: □ Psoriasis (PsO) □ Psoriatic Arthritis (PsA) □ Hidradenitis Suppurativa (HS) □ Atopic dermatitis □ Other: _____

Treatment status: □ New to therapy, previously denied by insurance: □ No □ Yes, include copy of denial letter Enroll in copay card/ bridge program if available and eligible: □ No □ Yes

□ Continuation of therapy, start date: ___/___/_____ Is the patient on samples? □ No □ Yes Weight: _____ □ kg □ lb, Height: _____ □ cm □ in

TB test results (within 6 months): □ N/A □ Negative □ Positive, Date of TB test: ___/____/_____ Allergies: □ NKDA □ Other: _____

Prior therapy, reason for discontinuation, and treatment dates: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
□ Cosentyx (secukinumab)	□ 150 mg/mL Sensoready pen □ 150 mg/mL PFS	□ Initial Dose: Inject 300 mg (2 x 150 mg) SC once a week for 5 weeks (on days 1, 8, 15, 22, and 29)	56 days	0
		Maintenance Dose: □ Inject 300 mg (2 x 150 mg) SC every 4 weeks □ Inject 150 mg SC every 4 weeks	□ 28 days □ 84 days	_____
□ Dupixent (dupilumab)	300 mg/2 mL PFS	□ Initial Dose: Inject 600 mg (2 x 300 mg) SC on day 1, then 300 mg every 2 weeks starting on day 15	42 days	0
		□ Maintenance Dose: Inject 300 mg SC every 2 weeks	□ 28 days □ 84 days	_____
□ Enbrel (etanercept)	□ 50 mg/mL SureClick pen □ 50 mg/mL PFS □ 25 mg/0.5 mL PFS	□ Initial Dose: Inject 50 mg SC twice a week (72—96 hours apart)	84 days	0
		□ Maintenance Dose: Inject 50 mg SC once a week	□ 28 days □ 84 days	_____
□ Humira (adalimumab)	□ PsO Starter Kit: 4 x 40 mg pen □ 40 mg PFS	Initial Dose (for PsO): Inject 80 mg (2 x 40 mg) SC on day 1, then 40 mg every 2 weeks starting on day 8	35 days	0
	□ HS Starter Kit: 6 x 40 mg pen □ 40 mg PFS	Initial Dose (for HS): □ Inject 160 mg (4 x 40 mg) SC on day 1, then 80 mg (2 x 40 mg) on day 15 □ Inject 80 mg (2 x 40 mg) SC on days 1, 2, and 15	28 days	0
	□ 40 mg pen □ 40 mg PFS	Maintenance Dose: □ Inject 40 mg SC every 2 weeks □ Inject 40 mg SC once a week	□ 28 days □ 84 days	_____
□ Otezla (apremilast)	□ Starter Pack: 55 tablets	Initial dose: Take as directed per package instructions	28 days	0
	□ 30mg tablet	Maintenance dose: □ Take 1 tab PO BID □ Take 1 tab PO once a day (for severe renal impairment)	□ 30 days □ 90 days	_____
□ Remicade (infliximab) □ Inflectra (infliximab-dyyb) □ Renflexis (infliximab-abda) Patient weight: _____	100 mg vial	Initial Dose: □ Infuse _____ mg (____ mg/kg) IV over at least 2 hours on days 1, 15, and 43	3 doses	0
		Maintenance Dose: □ Infuse _____ mg (____ mg/kg) IV over at least 2 hours every 8 weeks	56 days	_____
Include: □ Sterile water for inj □ Sodium chloride 0.9% inj	10 mL vial 250 mL bag	Use 10mL to reconstitute each 100 mg infliximab vial before dilution Dilute reconstituted infliximab to a final concentration of 0.4 to 4 mg/mL	QS	_____
□ Siliq (brodalumab)	210 mg/1.5 mL PFS	□ Initial Dose: Inject 210 mg SC on days 1 and 8, then every 2 weeks starting on day 15	42 days	0
		□ Maintenance Dose: Inject 210 mg SC every 2 weeks	□ 28 days □ 84 days	_____
□ Stelara (ustekinumab) Patient weight: _____	□ 45 mg/0.5 mL PFS □ 90 mg/ mL PFS	□ Initial Dose: Inject SC on day 1, then 4 weeks later on day 29	2 doses	0
		□ Maintenance Dose: Inject SC every 12 weeks	84 days	_____
□ Tremfya (guselkumab)	100 mg/mL PFS	□ Initial Dose: Inject 100mg SC on day 1, then 4 weeks later on day 29	2 doses	0
		□ Maintenance Dose: Inject 100mg SC every 8 weeks	56 days	

Prescriber Information [Ship to prescriber: □ Never □ Always □ First fill only, appointment date: ___/___/_____] Use Cover My Meds: □ No □ Yes

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted)

_____ □ Substitution allowed Date

_____ □ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: