**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.

**Twin Oaks Specialty Pharmacy**
**Your Specialty Partner**
**Phone: 855-793-TOSP (8677)**
**Fax: 855-909-TOSP (8677)**

# Dermatology 2 Referral Form

**Date Medication Needed:** ______ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): ______ Injection training by pharmacy?

## 1: Patient Information | Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

**Patient Name:** ______ **Birthdate:** ______ **Sex:** Male Female **Height:** ______ **Weight:** ______ lbs. kg.

**Soc. Sec. #:** ______ **Preferred Phone:** ______ **Known Allergies:** ______

**Address:** ______ **City:** ______ **State:** ______ **Zip:** ______

**Alternate Caregiver Name:** ______ **Preferred Phone:** ______

## 2: Prescriber Information

______ ______ **DEA#:** ______ **NPI#:** ______ **Tax ID#:** ______

**Address:** ______ **Phone:** (____) ______ - ______ **Fax:** (____) ______ - ______

**City:** ______ **State:** ______ **Zip:** ______ **Key Contact:** ______ **Phone:** (____) ______ - ______

## 3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

**Diagnosis:** ______

**Date of Diagnosis (or years with disease):** ______

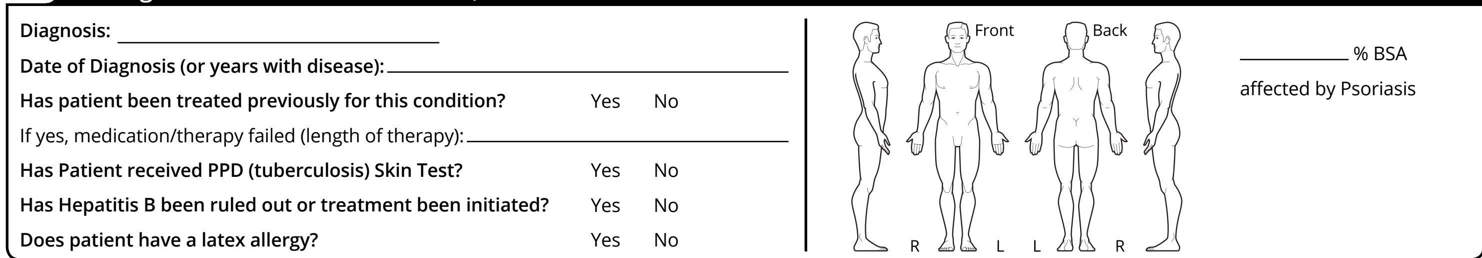
**Has patient been treated previously for this condition?** Yes No

If yes, medication/therapy failed (length of therapy): ______

**Has Patient received PPD (tuberculosis) Skin Test?** Yes No

**Has Hepatitis B been ruled out or treatment been initiated?** Yes No

**Does patient have a latex allergy?** Yes No




______ % BSA affected by Psoriasis

## 4: Prescription Information

| Medication | Dose/Strength | Sig | Qty. | Refills |
|---|---|---|---|---|
| Absorica®<br>Accutane®<br>Amnesteem®<br>Claravis®<br>Sotret®<br>Zenatane® | 10mg tablets<br>20mg tablets<br>30mg tablets<br>40mg tabelts | Take 1 tablet by mouth twice daily, with or without food | | |
| Epiduo® (Gel) | 1mg (.1%) adapalene &<br>25mg (2.5%) benzoyl peroxide | Apply a thin film of EPIDUO gel to affected areas of the face and/or trunk once daily after washing. Use a pea-sized amount for each area of the face (e.g., forehead, chin, each cheek). Avoid the eyes, lips and mucous membranes. | | |
| Erivedge® | 150mg tablets | Take 1 tablet by mouth once daily | | |
| Otrexup® (methotrexate)<br>Rasuvo® (methotrexate) | 10mg auto-injector<br>12.5mg auto-injector<br>15mg auto-injector<br>17.5mg auto-injector<br>20mg auto-injector<br>22.5mg auto-injector<br>25mg auto-injector | Inject contents of one pen, subcutaneously, once weekly | | |
| Picato® (Gel) | .0015% ingenol mebutate<br>.05% ingenol mebutate | Apply Gel to the affected area once daily for ______ consecutive days | | |
| Targretin® (Gel) | 1% bexarotene | Apply every other day for 1 week then at weekly intervals increase to once daily; then twice daily, then three times daily, and finally four times daily. | | |
| Valchlor® (Gel) | .016% mechlorethamine | Apply a thin film once daily to affected areas of the skin | | |
| Ziana® (Gel) | 1.2% clindamycin phosphate<br>& .025% tretinoin | Apply a pea-sized amount to the entire face once daily at bedtime. Do not apply to eyes, mouth, angles of the nose, or mucous membranes | | |
| | | | | |

**Patient Support Programs:** Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ______ Date: ______

**Prescriber Signature:** Prescriber, please sign and date below

Dispense as written ______ Date ______ Substitution Permissable ______ Date ______

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
**Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

**# of Prescriptions:** ______