Galaxy SPECIALTY PHARMACY
(Christus SantaRosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Dermatology Prescription Referral Form

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.com

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:** ______________

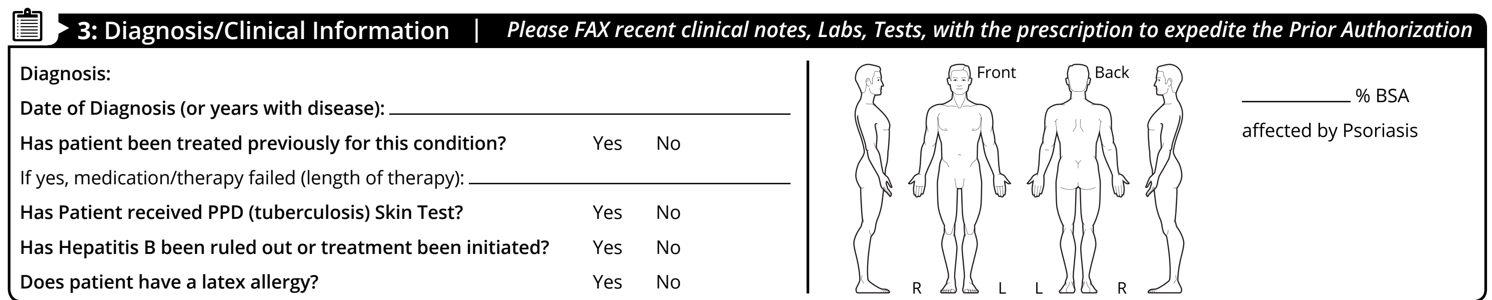
2: Prescriber Information

______________ ______________ **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
Enbrel®	50mg/ml Prefilled Syringe 50mg/ml SureClick™ Autoinjector 25mg/0.5ml Prefilled Syringe	**Induction Dose:** Inject 50mg SC TWICE a week *(72-96 hours apart for three months)* **Maintenance Therapy:** Inject 50mg SC ONCE a week **Other:**		
Humira® Injection training from My Humira ***(patient must sign below)***	20mg/0.4ml Prefilled Syringe *(2 doses)* 40mg/0.8ml Pen (2 doses) 40mg/0.8ml Prefilled Syringe *(2 doses)* 40mg Kit 4x0.8ml 40mg Starter Kit 6x0.8ml	**Initial Dose:** Inject 80mg SC on Day 1 **Maintenance Therapy:** Inject 40mg SC every other week (starting 1 week after initial dose) **Other:**	Initial Dose: 1 Other:	
Stelara®	45mg/0.5ml Prefilled Syringe 90mg/1ml Prefilled Syringe	**Starter Dose:** Inject 45mg SC **(patient <100 kg)** at Day 1 Inject 90mg SC **(patient >100 kg)** at Day 1 **Maintenance:** Inject 45mg SC **(patient <100 kg)** *29 days after starter dose and then every 12 weeks* Inject 90mg SC **(patient >100 kg)** *29 days after starter dose and then every 12 weeks* **Other:**	Initial Dose: 1 Other:	
Otezla®				
Oxsoralen-Ultra®	10mg			
Targretin® *(Capsules)*	75mg capsules			
Targretin® *(Gel)*	1% gel	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™	0.016% gel	Apply a thin film once daily to the affected areas of the body. Directions, if different from above: ______________		
Zolinza®	400mg	400mg once daily **Other:**		

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: ______________