

DERMATOLOGY REFERRAL

Fax Referral:



Dat e: _____ ☐ Current Patient ☐ New

Phone: _____

Patient Needs by Date: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance: _____
ID#: _____ Group: _____
Secondary Insurance: _____
ID#: _____ Group: _____
Prescription Card: _____ ID#: _____
BIN: _____ PCN: _____ Group: _____

PRESCRIBER INFORMATION

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

Clinical Information (Please fax all pertinent clinical information)

Diagnosis: ☐ L20.9 (Atopic Dermatitis) ☐ L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) ☐ L40.8 (Other Psoriasis)
☐ L40.9 (Psoriasis, unspecified) ☐ L40.5 (Psoriatic Arthritis) ☐ L73.2 (Hidradenitis Suppurativa) ☐ _____
Diagnosis Date: _____ **TB Test:** ☐ Yes ☐ No **Neg. Test Date** _____
HBV: ☐ Yes ☐ No If yes, currently treated: ☐ Yes ☐ No **Allergies:** _____
BSA affected (%): _____ **Affected areas:** ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ _____ **Prior Therapy:** ☐ Yes ☐ No
Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____ **Approximate End Date:** _____

Medication	Dose/Strength	Directions	Quantity	Refills
Cimzia	<input type="checkbox"/> 6 X 200 mg/mL (PFS Starter Kit) <input type="checkbox"/> 2 X 200 mg/mL PFS <input type="checkbox"/> 2 X 200 mg/mL Vial	<input type="checkbox"/> Inject 400mg sc at weeks 0, 2, and 4 <input type="checkbox"/> Inject 200mg sc every 2 weeks <input type="checkbox"/> Inject 400mg sc every 4 weeks <input type="checkbox"/> For some patients <90 kg: Inject 400 mg sc at weeks 0, 2, and 4, then 200 mg every 2 weeks		
Dupixent	<input type="checkbox"/> 300mg PFS	<input type="checkbox"/> Starter dose: Inject 300mg SC on day 1 and day 15 <input type="checkbox"/> Maintenance: Inject 300mg SC every 2 weeks thereafter		
Enbrel	<input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 50mg/ml SureClick Autoinjector <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 50mg SC twice a week (72-96 hrs apart for 3 months) <input type="checkbox"/> Maintenance: Inject SC every 4 weeks		
Humira	<input type="checkbox"/> 20mg/0.2mL Pen <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.8mL Pen or Syringe <input type="checkbox"/> 40mg Kit 4 X 0.8 ml <input type="checkbox"/> 40mg Psoriasis Starter Pack	<input type="checkbox"/> Starter Dose: Inject 80mg SC on Day 1 <input type="checkbox"/> Maintenance: Inject 50mg SC once weekly thereafter Other: _____		
Ilumya	<input type="checkbox"/> 100mg/1ml Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 100mg SC 0, 4 <input type="checkbox"/> Maintenance: 100mg SC every 12 weeks		
Orencia	<input type="checkbox"/> 125mg PFS <input type="checkbox"/> 250mg/mL Vial <input type="checkbox"/> 125mg ClickJect Pen	<input type="checkbox"/> Starter Dose: Infuse _____ mg at week 0, 2, and 4 <input type="checkbox"/> Maintenance Infuse _____ mg at every 4 week thereafter (<60kg=500mg, 60 to 100kg=750mg, >100kg=1000mg)		
Otezla	<input type="checkbox"/> 30 mg	<input type="checkbox"/> 2 X Daily <input type="checkbox"/> 28 Day Starter Pack		
Remicade / Renflexis / Inflectra	<input type="checkbox"/> 100 mg Vial	Starter Dose: <input type="checkbox"/> 5mg/kg (dose _____ mg) IV at 0.2 and 6 weeks, then every 8 weeks thereafter Maintenance: <input type="checkbox"/> 5mg/kg (Dose _____ mg) IV every 8 weeks <input type="checkbox"/> IV _____ mg every _____ weeks		
Simponi/ Simponi Aria	<input type="checkbox"/> 100 mg/ml Autoinjector <input type="checkbox"/> 100 mg/ml PFS <input type="checkbox"/> 50mg/ml Autoinjector <input type="checkbox"/> 50 mg/ml PFS <input type="checkbox"/> 50 mg/4ml vial	<input type="checkbox"/> Inject 100 mg SC once a month <input type="checkbox"/> Inject 50 mg SC once a month <input type="checkbox"/> Infuse _____ mg (2mg/kg00 over 30 minutes at 0 and 4, then every 8 weeks)	<input type="checkbox"/> 4-wk supply <input type="checkbox"/> Other: _____	
Stelara	<input type="checkbox"/> 45 mg/0.5 ml PFS <input type="checkbox"/> 90 mg/1.0 ml PFS	Starter Dose: <input type="checkbox"/> Inject 45mg SC (pt<100kg) on day 1 and day 28 for starter dose <input type="checkbox"/> Inject 90mg SC (pt>100kg) on day 1 and day 28 for starter dose Maintenance: <input type="checkbox"/> Inject 45 mg SC (pt<100kg) every 12 weeks thereafter. <input type="checkbox"/> Inject 90 mg sc (pt>100kg) every 12 weeks thereafter	<input type="checkbox"/> Initial Dose 1 <input type="checkbox"/> Other: _____	
Tremfya	<input type="checkbox"/> 100mg/1ml Prefilled Syringe	<input type="checkbox"/> Inject 100 mg sq on week 0 and 4 (Qty 1 plus 1 refill) <input type="checkbox"/> Inject 100 mg sq every 8 weeks (Qty 1)		
Xeljanz/XR	<input type="checkbox"/> 5 mg <input type="checkbox"/> 11mg	<input type="checkbox"/> Take 5 mg po, bid <input type="checkbox"/> Take 11 mg po once daily		

Other/Notes: _____

Prescriber Signature: _____

DAW (Dispense as Written) Date: _____

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