

DERMATOLOGY REFERRAL FORM

SUPERIOR BIOLOGICS
Fax Referral To: 877-521-5353
Phone: 800-521-3949



Date: _____

Patient Information

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 DOB: _____
 Gender: M F

Prescriber Information

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

Insurance Information

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

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)
 M33 (Dermatopolymyositis) M33.1 (Dermatomyositis) L12.9 (Pemphigoid/Pemphigus) L10.0 (Pemphigus Vulgaris)
 Diagnosis Date: _____ Height: _____ Weight: _____ Tb Test: Yes No Neg. Text 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: _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Cimzia	<input type="checkbox"/> 6 x 200mg/mL (PFS Starter Kit) <input type="checkbox"/> 2 x 200mg/mL PFS <input type="checkbox"/> 2 x 200mg/mL Vial	<input type="checkbox"/> Inject 400mg SUBQ at weeks 0, 2 and 4 <input type="checkbox"/> Inject 200mg SUBQ every 2 weeks <input type="checkbox"/> Inject 400mg SUBQ every 4 weeks <input type="checkbox"/> For some patients <90kg: Inject 400mg SUBQ at weeks 0, 2 and 4, then 200mg every 2 weeks		
Cosentyx	<input type="checkbox"/> 300mg Sensoready Pen <input type="checkbox"/> 150mg Sensoready Pen	<input type="checkbox"/> Starter Dose: Inject SUBQ weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance Dose: Inject SUBQ every 4 weeks		
Dupixent	<input type="checkbox"/> 300mg PFS <input type="checkbox"/> 200mg PFS	<input type="checkbox"/> Starter Dose: Inject 400 mg (two 200 mg injections) <input type="checkbox"/> Starter Dose: Inject 600 mg (two 300 mg injections) <input type="checkbox"/> Maintenance Dose: Inject 200mg SUBQ every 2 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 300mg SUBQ 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 SUBQ twice a week (72-96 hours apart for 3 months) <input type="checkbox"/> Maintenance Dose: Inject SUBQ 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 0.8mL <input type="checkbox"/> 40mg Psoriasis Starter Pack	<input type="checkbox"/> Starter Dose: Inject 80mg SUBQ on Day 1 <input type="checkbox"/> Maintenance Dose: Inject 40mg SUBQ once weekly thereafter Other: _____	<input type="checkbox"/> Initial Dose 1: Other: _____ <input type="checkbox"/> Injection training required from my Humira	
Ilumya	<input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 100mg SUBQ at weeks 0 and 4 <input type="checkbox"/> Maintenance Dose: 100mg SUBQ every 12 weeks		

Prescriber Signature: _____ DAW (Dispense as Written) Date: _____

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 Arthritis M33 (Dermatopolymyositis) M33.1 (Dermatomyositis) 2.9 (Pemphigoid/Pemphigus) L10.0 (Pemphigus Vulgaris)
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Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
IVI Orders		_____mg/kg IV divided over _____day(s) _____mg/kg IV divided over _____day(s) Frequency: <input type="checkbox"/> Every _____ weeks for one year <input type="checkbox"/> one time dose		
Orencia	<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 250mg/mL Vial <input type="checkbox"/> 125mg ClickJect Pen	<input type="checkbox"/> Starter Dose: Infuse _____mg at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: Infuse _____mg at every 4 weeks thereafter (<60kg = 500mg, 60kg to 100kg = 750mg, and >100kg = 1000mg) <input type="checkbox"/> SC: Inject 125mg SUBQ once a week		
Otezla	<input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> 30mg	<input type="checkbox"/> Starter Pack: Take as Directed <input type="checkbox"/> Maintenance Dose: Take 1 Table BID		
<input type="checkbox"/> Remicade <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Starter Dose: 5mg/kg (dose _____mg) IV at 0, 2, and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 5mg/kg (dose _____mg) IV every 8 weeks IV _____mg every _____weeks		
Rituxan	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Loading Dose: 1000mg IV at Day 0 and Day 15 <input type="checkbox"/> Maintenance Dose: 50mg IV at month 12 and every 6 months thereafter		
Siliq	<input type="checkbox"/> 210mg/1.5mL PFS	<input type="checkbox"/> Loading Dose: Inject 210mg SUBQ at weeks 0,1, and 4 <input type="checkbox"/> Maintenance Dose: 210mg SUBQ every 2 weeks thereafter	<input type="checkbox"/> Starter Dose: 3 PFS <input type="checkbox"/> Maintenance Dose 2 PFS	

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DOB: _____	DEA: _____ NPI #: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

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Prescription Information				
Medication	Dose Strength	Directions	Qty	Refills
Simponi / Simponi Aria	<input type="checkbox"/> 100mg/mL Autoinjector <input type="checkbox"/> 100mg/mL PFS <input type="checkbox"/> 50mg/mL Autoinjector <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/4mL Vial	<input type="checkbox"/> Inject 100mg SUBQ once a month <input type="checkbox"/> Inject 50mg SUBQ once a month <input type="checkbox"/> Infuse _____mg (2mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks)	<input type="checkbox"/> 4 week supply	
Skyrizi	<input type="checkbox"/> 75mg/0.83mL (150mg dose)	<input type="checkbox"/> Initial Dose: Inject 150mg SUBQ weeks 0, and 4 <input type="checkbox"/> Maintenance Dose: Inject 150mg SUBQ every 12 weeks		
Stelara	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/1.0mL PFS	Starter Dose: <input type="checkbox"/> Inject 45mg SUBQ (pt<100kg) on Day 1 and Day 28 <input type="checkbox"/> Inject 90mg SUBQ (pt>100kg) on Day 1 and Day 28 Maintenance Dose: <input type="checkbox"/> Inject 45mg SUBQ (pt<100kg) every 12 weeks thereafter <input type="checkbox"/> Inject 90mg SUBQ (pt>100kg) every 12 weeks thereafter	<input type="checkbox"/> Initial Dose: 1 other: _____	
Taltz	<input type="checkbox"/> 80mg/mL Autoinjector	<input type="checkbox"/> Starter Dose: Inject 160mg SUBQ at week 0, then 80mg at weeks 2, 4, 6, 8, 10, and 12 weeks <input type="checkbox"/> Maintenance Dose: Inject 80mg SUBQ every 4 weeks		
Tremfya	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Inject 100mg SUBQ on weeks 0 and 4 <input type="checkbox"/> Inject 100mg SUBQ every 8 weeks	<input type="checkbox"/> 1 Plus Refill <input type="checkbox"/> 1	
Xeljanz/XR		<input type="checkbox"/> Take 5mg PO BID <input type="checkbox"/> Take 11mg PO once daily		

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