

## DERMATOLOGY REFERRAL FORM

**SUPERIOR BIOLOGICS**  
**Fax Referral To: 914-747-1170**  
**Phone: 855-747-1150**



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"/> <b>Starter Dose:</b> Inject SUBQ weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject SUBQ every 4 weeks		
Dupixent	<input type="checkbox"/> 300mg PFS <input type="checkbox"/> 200mg PFS	<input type="checkbox"/> <b>Starter Dose:</b> Inject 400 mg (two 200 mg injections) <input type="checkbox"/> <b>Starter Dose:</b> Inject 600 mg (two 300 mg injections) <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 200mg SUBQ every 2 weeks thereafter <input type="checkbox"/> <b>Maintenance Dose:</b> 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"/> <b>Starter Dose:</b> Inject 50mg SUBQ twice a week (72-96 hours apart for 3 months) <input type="checkbox"/> <b>Maintenance Dose:</b> 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"/> <b>Starter Dose:</b> Inject 80mg SUBQ on Day 1 <input type="checkbox"/> <b>Maintenance Dose:</b> 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"/> <b>Starter Dose:</b> Inject 100mg SUBQ at weeks 0 and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> 100mg SUBQ every 12 weeks		

Prescriber Signature: \_\_\_\_\_ DAW (Dispense as Written) Date: \_\_\_\_\_

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 Contact Person: \_\_\_\_\_

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**Clinical Information (please fax all pertinent clinical information)**

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 L40.9 (Psoriasis/Unspecified)  L40.5 (Psoriatic)  L73.2 (Hidradenitis Suppurativa)  
 Arthritis  M33 (Dermatopolymyositis)  M33.1 (Dermatomyositis)  2.9 (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
IVI Orders		_____mg/kg IV divided over _____day(s) _____mg/kg IV divided over _____day(s) <b>Frequency:</b> <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"/> <b>Starter Dose:</b> Infuse _____mg at weeks 0, 2, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse _____mg at every 4 weeks thereafter (<60kg = 500mg, 60kg to 100kg = 750mg, and >100kg = 1000mg) <input type="checkbox"/> <b>SC:</b> Inject 125mg SUBQ once a week		
Otezla	<input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> 30mg	<input type="checkbox"/> <b>Starter Pack:</b> Take as Directed <input type="checkbox"/> <b>Maintenance Dose:</b> 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"/> <b>Starter Dose:</b> 5mg/kg (dose _____mg) IV at 0, 2, and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> <b>Maintenance Dose:</b> 5mg/kg (dose _____mg) IV every 8 weeks IV _____mg every _____weeks		
Rituxan	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> <b>Loading Dose:</b> 1000mg IV at Day 0 and Day 15 <input type="checkbox"/> <b>Maintenance Dose:</b> 50mg IV at month 12 and every 6 months thereafter		
Siliq	<input type="checkbox"/> 210mg/1.5mL PFS	<input type="checkbox"/> <b>Loading Dose:</b> Inject 210mg SUBQ at weeks 0,1, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> 210mg SUBQ every 2 weeks thereafter	<input type="checkbox"/> Starter Dose: 3 PFS <input type="checkbox"/> Maintenance Dose 2 PFS	

**Prescriber Signature:** \_\_\_\_\_ **DAW (Dispense as Written) Date:** \_\_\_\_\_

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Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
DOB: _____	DEA: _____ NPI #: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	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: <input type="checkbox"/> L20.9 (Atopic Dermatitis) <input type="checkbox"/> L40.0 (Psoriasis Vulgaris/Plaque Psoriasis/Nummular Psoriasis) <input type="checkbox"/> L40.8 (Other Psoriasis)	<input type="checkbox"/> L40.9 (Psoriasis/Unspecified) <input type="checkbox"/> L40.5 (Psoriatic Arthritis) <input type="checkbox"/> L73.2 (Hidradenitis Suppurativa)
<input type="checkbox"/> M33 (Dermatopolymyositis) <input type="checkbox"/> M33.1 (Dermatomyositis) <input type="checkbox"/> L12.9 (Pemphigoid/Pemphigus)	<input type="checkbox"/> L10.0 (Pemphigus Vulgaris) Diagnosis Date: _____ Height: _____ Weight: _____
Tb Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Neg. Text Date: _____ HBV: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Currently Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies: _____ BSA Affected (%): _____ Affected Areas: <input type="checkbox"/> Palms <input type="checkbox"/> Soles <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia <input type="checkbox"/> Prior Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____	Approximate End Date: _____

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"/> <b>Initial Dose:</b> Inject 150mg SUBQ weeks 0, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 150mg SUBQ every 12 weeks		
Stelara	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/1.0mL PFS	<b>Starter Dose:</b> <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 <b>Maintenance Dose:</b> <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"/> <b>Starter Dose:</b> Inject 160mg SUBQ at week 0, then 80mg at weeks 2, 4, 6, 8, 10, and 12 weeks <input type="checkbox"/> <b>Maintenance Dose:</b> 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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