Dermatology Referral Form A-M

Fax #: ________________________

Patient Information

Patient Name: ________________________ DOB: ___________ SS#: ______________ Ship To: □ Home □ Clinic

Address: ____ City: _______________________ State: ______Zip________

Phone(day): _________________________ Phone (night): _______________________ Cell: ______________________________

Rx Insurance: _______________________ Group #: __________________ ID #: _________________ RX Bin #:______________

Medical Insurance: ______________________ Group #: __________________ ID #: _________________ Phone :_____________

Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** □ L40.8 Plaque Psoriasis □ L40.50 Psoriatic Arthritis □ L73.2 Hidradenitis Suppurativa □ Other: _______________

2. **Drug Allergies:** ____

3. **Failed Medications: (When)** □ Soriatane _______________ □ MTX ____________ □ Biologics ___________________ □ PUVA / UVB ____________ □ Topicals __________ □ Other _______________________

4. **Negative TB Skin Test (PPD Test):** □ Yes □ No When: __________ (Please Attach)

5. **Location:** % BSA: _______ □ Hands □ Feet □ Scalp □ Groin □ Nails □ Other: ______________________________

Allergies: _________________________________ **Current Medication:** ____

Medication

Cimzia 200mg / ml
__ Inject 400mg SC every other week — Quantity: 28 day supply — Refills: ____
__ Other: _______________________________

Cosentyx 150mg
___ 150mg Pen
___ 150mg Prefilled Syringe
___ Loading Dose: Inject __ 300mg or __ 150mg SQ at week 0, 1, 2, 3, and 4 — Quantity # _____ — Refills 0
___Maintenance: Inject __300mg or __ 150mg SQ every 4 weeks

Dupixent
__ 300mg/ 2 ml PFS w/shield
__ 300mg/ 2 ml PFS w/o shield
__ Load: Inject 600mg SQ on day 1 — Quantity # 2 syringes
__ Maintenance: Inject 300mg SQ every 2 weeks starting on day 15 — Quantity # 2 syringes — Refills: ____

Enbrel __ Sureclick __ Prefilled Syringe
____ 50 mg Loading: Inject 50mg twice weekly for 3 months — Quantity # 28 day supply — Refills _____
____ 25 mg Maintenance: Inject Enbrel ______ mg SQ ______ x per week

__ Enbrel Mini — Quantity # 28 day supply — Refills _____

Erivedge 150mg
__ Take one capsule by mouth daily — Quantity: 28 day supply — Refills: ____

Humira 40 mg (Psoriasis Starter Pack) __ Citrate Free (40mg / 0.4ml) __ Regular (40mg / 0.8ml)
Inject 80mg (2x40mg) SQ on day 1 — Quantity # 1 — Refills 0
Inject 40mg SQ every other week starting on week two

Humira 40mg (standard maintenance) __ Citrate Free (40mg / 0.4ml) __ Regular (40mg / 0.8ml)
___ Inject 40mg SQ every other week — Quantity # _____ — Refills _____
___ Other ___________________________

Humira 40 mg (Hidradenitis Suppurativa Starter Pack) __ Citrate Free (40mg / 0.4ml) __ Regular (40mg / 0.8ml)
160mg SQ on day 1(Week 0)
80mg SQ on day 15 — Quantity # 1 — Refills 0

Humira 40mg (Hidradenitis Suppurativa maintenance) __ Citrate Free (40mg /0.4ml) __ Regular (40mg / 0.8ml)
Inject 40mg SQ on day 29 and then every week thereafter — Quantity # _____ — Refills _____

Physician Prescription Orders

Physician Name: __________________________ NPI #: ______________ Phone: _________________ Fax: ________________

Address: ____ Nurse: ______________ Date: ______________

Physician Signature: ____________________________________