Dermatology Referral Form N-Z

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

Medication	Directions	Quantity	Refills
Odomzo 200mg	__ Take one capsule by mouth on an empty stomach, One hour before or two hours after a meal	Quantity: 30 day supply	Refills _____
Otezla			
__ Starter Pack	__ Take 1 tablet on day 1 then twice daily as directed	Quantity # 1 Pack	
__ 30 mg Tablets	__ Take 1 tablet by mouth twice daily	Quantity # 60	Refills _____
Siliq 210mg	__ Load: Inject 210mg SQ at weeks 0,1, and 2 and then Every two weeks.	Quantity: #4 syringes	Refills: 0
	__ Maintenance: Inject 210mg SQ every 2 weeks	Quantity:#2 syringes	Refills: ____
Simponi 50mg	Inject 50mg SC once a month as directed		
___ 50mg Smartject		Quantity # _____	Refills ______
___ 50mg Prefilled Syringe			
Stelara 45mg _____	Inject _____ mg on day 1, then week 4, then every 12 weeks		
Stelara 90mg _____		Quantity # _____	Refills _____
Taltz 80mg/ml __ AutoInjector __ Prefilled Syringe	__Load: Inject 160mg SQ on week 0, then 80mg week 2,	Quantity: #3	Refills: 0
	then 80mg on weeks 4,6,8,10, then	Quantity: #2	Refills: 1
	Inject 80 mg at week 12	Quantity: #1	Refills: 0
	__Load (Psoriatic Arthritis): Inject 160mg SQ on day 1	Quantity: #2	Refills: 0
	__ Maintenance: Inject 80mg SQ every 4 weeks	Quantity: #1	Refills: ____
Tremfya 100mg/ml			
__ Inject 100mg SQ on week 0 and week 4		Quantity: #1	Refills: #1
__ Inject 100mg SQ every 8 weeks		Quantity: #1	Refills: ___

Physician Prescription Orders

Physician Name: ________________________ NPI #: ___________________ Phone: _________________ Fax: ________________

Address: ____ Nurse: ______________ Date: ______________

Physician Signature: ____________________________________