Dermatology Referral Form

Fax #: _____

Patient Information

Patient Name: _____ DOB: _____ SS#: _____ Ship To: □ Home □ Clinic

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:** □ Soriatane _____ □ MTX _____ □ Biologics _____
   (When) □ 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

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

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

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 _____

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

Taltz 80mg/ml __ AutoInjector __Load: Inject 160mg SQ on week 0, then 80mg week 2, Quantity: #3 Refills: 0
__ Prefilled Syringe 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: ____

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: ____

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

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Phone: _____ Fax: _____
Address: _____ Nurse: _____ Date: _____

Physician Signature: _____