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 Inject Enbrel _____ mg subcutaneously _____ x per week
__ Prefilled Syringe ____ 25 mg Quantity: 28 day supply Refills ____

Humira 40 mg / 0.8 ml (Starter Pack)
____ Inject 80mg (2x40mg) SQ on day 1 Quantity # _____ Refills _____
____ Inject 40mg SQ every other week starting on week two
____Other: _____

Humira 40 mg / 0.8 ml (Hidradenitis Suppurativa Starter Pack) NDC # 0074-4339-06
160mg SQ on Day 1(Week 0)
____ Four 40mg SQ on day 1 - OR- ____ Two 40mg SQ on day 1 & 2 Quantity # 1 Refills 0

80mg SQ on Day 15 (Week 2)
Alternate Dosage: _____

Humira 40mg / 0.8 ml (maintenance)
_____ Inject 40mg SQ every other week Quantity # _____ Refills _____
____ Other _____

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 Starter Pack
__ 30 mg Tablets __ Take 1 tablet by mouth twice daily Quantity # 60 Refills _____

Dupixent __ Load: Inject 600mg on day 1 , then 300mg Quantity: 4 syringes Refills 0
__ 300mg/ 2 ml PFS w/shield on day 15, then 300mg every other week
__ 300mg/ 2 ml PFS w/o shield __ Maintenance: Inject 300mg SQ every other week 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: ___

Physician Prescription Orders

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

Physician Signature: _____