

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

## DERMATOLOGY REFERRAL FORM

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

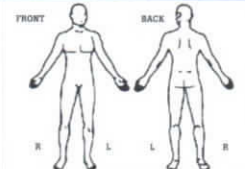
### PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

### PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

<b>Diagnosis (ICD-10)</b> <input type="checkbox"/> L40.50 Arthropathic Psoriasis (unspecified) <input type="checkbox"/> L40.51 Distal Interphalangeal Psoriatic Arthropathy <input type="checkbox"/> L40.52 Psoriatic Arthritis Mutilans <input type="checkbox"/> L40.53 Psoriatic Spondylitis <input type="checkbox"/> L40.59 Other Psoriatic Arthropathy <input type="checkbox"/> L40.0 Psoriasis Vulgaris <input type="checkbox"/> L40.8 Other Psoriasis <input type="checkbox"/> L40.9 Psoriasis (unspecified) <input type="checkbox"/> L73.2 Hidradenitis Suppurativa (HS)	<input type="checkbox"/> Other ICD-10 _____ Date of Diagnosis _____ Years w/Disease _____		BSA % Affected by Psoriasis _____
<b>Medical Assessment (Within Last 12 Months)</b> Psoriasis Severity: <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe Psoriasis Type: <input type="checkbox"/> Plaque <input type="checkbox"/> Other _____ <input type="checkbox"/> Specialty Pharmacy to Coordinate Injection Training/ Home Health Nurse as Needed <input type="checkbox"/> YES <input type="checkbox"/> NO	Has patient been diagnosed with Lymphoma: <input type="checkbox"/> YES <input type="checkbox"/> NO Does patient have a latex allergy: <input type="checkbox"/> YES <input type="checkbox"/> NO Is patient's platelet count > 52,000 cells/uL <input type="checkbox"/> YES <input type="checkbox"/> NO		

### PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
<input type="checkbox"/> Cosentyx*	<input type="checkbox"/> 300mg <input type="checkbox"/> 150mg	<input type="checkbox"/> Starter Dose: Inject SQ at weeks 0, 1, 2, 3 and 4 <input type="checkbox"/> Maintenance Dose: Inject SQ every 4 weeks <input type="checkbox"/> Other: _____		0
<input type="checkbox"/> Dupixent*	<input type="checkbox"/> 300mg/2mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: 600mg SC divided in 2 different injection sites <input type="checkbox"/> Maintenance Dose: 300mg SC every other week	2 2	0
<input type="checkbox"/> 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"/> Starter Dose: Inject 50mg SC TWICE a week (72-96 hours apart for three months) <input type="checkbox"/> Maintenance Dose: Inject 50mg SC ONCE a week <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Humira* <input type="checkbox"/> Injection training from MyHumira (patient must sign below)	<input type="checkbox"/> 20mg/0.4ml Prefilled Syringe (2 doses) <input type="checkbox"/> 40mg/0.8ml Pen (2 doses) <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe (2 doses) <input type="checkbox"/> 40mg Kit 4x0.8ml <input type="checkbox"/> 40mg Starter Kit 6x0.8ml	<input type="checkbox"/> Starter Dose: <input type="checkbox"/> Hidradenitis Suppurativa: Inject 160mg SC in day 1, then 80mg on day 15 <input type="checkbox"/> Plaque Psoriasis: Inject 80mg SC day 1, then 40mg on day 8, and then 40mg every 2 weeks thereafter <input type="checkbox"/> Other: _____ <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Hidradenitis Suppurativa: Inject 40mg SC on day 29 and then every week thereafter <input type="checkbox"/> Plaque Psoriasis: Inject 40mg SC every 2 weeks	1 Pack	0 refills for Starter dose
<input type="checkbox"/> Otelza*	<input type="checkbox"/> Tiration Starter Pack Rx <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Other: _____	1 Pack	0
<input type="checkbox"/> Siliq*	<input type="checkbox"/> 210mg/1.5mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: <input type="checkbox"/> 210mg SC on weeks 0, 1, 2 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 210mg SC every 2 weeks		0
<input type="checkbox"/> Simponi™	<input type="checkbox"/> 50mg/0.5mL Smartjet® Autoinjector <input type="checkbox"/> 50mg/0.5mL Prefilled Syringe	<input type="checkbox"/> Psoriatic Arthritis Dose: Inject 50mg (0.5mL) subcutaneously once a month <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Simponi Aria*		<input type="checkbox"/> 2mg/kg IV at weeks 0 and 4, then q 8 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Stelara*	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 90mg/1ml Prefilled Syringe	<input type="checkbox"/> Starter Dose: <input type="checkbox"/> Inject 45mg SC (patient <100 kg) at Day 1 <input type="checkbox"/> Inject 90mg SC (patient >100 kg) at Day 1 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Inject 45mg SC (patient <100 kg) 29 days after starter dose and then every 12 weeks <input type="checkbox"/> Inject 90mg SC (patient >100 kg) 29 days after starter dose and then every 12 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> Initial Dose: 1	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Taltz*	<input type="checkbox"/> Autoinjector 80mg/mL <input type="checkbox"/> Prefilled Syringe 80mg/mL	<input type="checkbox"/> Starter Dose: 160mg SQ at week 0; then inject 80mg SQ at weeks 2,4,6,8,10 & 12 <input type="checkbox"/> Maintenance Dose: 80mg SQ every 4 weeks		
<input type="checkbox"/> Tremfya™	<input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 100mg SC at week 0 and 4, then Q8W		
<input type="checkbox"/> Valchlor™	<input type="checkbox"/> 0.016% gel	Apply a thin film once daily to the affected area of the body. Directions, if different from above:		

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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