DERMATOLOGY REFERRAL FORM

Date: _____

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Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____
Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Clinical Information (please fax all pertinent clinical information)

Diagnosis: ☐ L20.9 (Atopic Dermatitis) ☐ L40.0 (Psoriasis Vulgaris/Plaque Psoriasis/Nummular Psoriasis) ☐ L40.8 (Other Psoriasis)
☐ L40.9 (Psoriasis/Unspecified) ☐ L40.5 (Psoriatic Arthritis) ☐ L73.2 (Hidradenitis Suppurativa)
☐ M33 (Dermatopolymyositis) ☐ M33.1 (Dermatomypsitis) ☐ L12.9 (Pemphigoid/Pemphigus) ☐ L10.0 (Pemphigus Vulgaris)
Diagnosis Date: _____ Height:_____ Weight:_____ Tb Test: ☐ Yes ☐ No Neg. Text Date: _____
HBV: ☐ Yes ☐ No If Yes, Currently Treated: ☐ Yes ☐ No Allergies: _____
BSA Affected (%): _____ Affected Areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ _____
Prior Therapy: ☐ Yes ☐ No Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____ Approximate End Date: _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Simponi / Simponi Aria	☐ 100mg/mL Autoinjector ☐ 100mg/mL PFS ☐ 50mg/mL Autoinjector ☐ 50mg/mL PFS ☐ 50mg/4mL Vial	☐ Inject 100mg SC once a month ☐ Inject 50mg SC once a month ☐ Infuse _____ mg (2mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks)	☐ 4 week supply	
Skyrizi	☐ 75mg/0.83mL (150mg dose)	☐ **Initial Dose:** Inject 150mg SC weeks 0, and 4 ☐ **Maintenance Dose:** Inject 150mg SC every 12 weeks		
Stelara	☐ 45mg/0.5mL PFS ☐ 90mg/1.0mL PFS	**Starter Dose:** ☐ Inject 45mg SC (pt<100kg) on Day 1 and Day 28 ☐ Inject 90mg SC (pt>100kg) on Day 1 and Day 28 **Maintenance Dose:** ☐ Inject 45mg SC (pt<100kg) every 12 weeks thereafter ☐ Inject 90mg SC (pt>100kg) every 12 weeks thereafter	☐ Initial Dose: 1 other: _____	
Taltz	☐ 80mg/mL Autoinjector	☐ **Starter Dose:** Inject 160mg SC at week 0, then 80mg at weeks 2, 4, 6, 8, 10, and 12 weeks ☐ **Maintenance Dose:** Inject 80mg SC every 4 weeks		
Tremfya	☐ 100mg PFS	☐ Inject 100mg SC on weeks 0 and 4 ☐ Inject 100mg SC every 8 weeks	☐ 1 Plus Refill ☐ 1	
Xeljanz/XR		☐ Take 5mg PO BID ☐ Take 11mg PO once daily		

Prescriber Signature: _____ DAW (Dispense as Written) Date: _____