

DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		SSN:	DOB:	Height:
Address:		City:	State:	Zip:
Home Phone:	Cell:	Email:	Gender: Male	Female

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Primary Diagnosis: Moderate to Severe Plaque Psoriasis Psoriatic Arthritis Hidradenitis Suppurativa Atopic Dermatitis Alopecia Areata Other: _____ Diagnosis Code(ICD-10): _____

Date of Diagnosis: _____ TB Test Completed On: _____ BSA: _____ Latex Allergy: Y N

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

<p>ADBRY™ (tralokinumab-ldm) 150 mg Prefilled Syringe <input type="checkbox"/> Induction: Inject 600 mg (4x150 mg) SubQ Qty: 4 Refills: None Maintenance: <input type="checkbox"/> Inject 300 mg (2 x150 mg) SubQ every other week <input type="checkbox"/> Inject 300 mg (2 x150 mg) SubQ every 4 weeks <input type="checkbox"/> ADBRY™ Bridge Care™ Program: Inject 300 mg (2x 150 mg) SubQ every other week starting on Day 15 Qty: _____ Refills: _____</p> <p>CIBINQO™ (abrocitinib) Tablet <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg mg PO once daily Qty: _____ Refills: _____</p> <p>Cimzia® (certolizumab pegol) Prefilled Syringe <input type="checkbox"/> Induction: Inject 2 x 200 mg/ml SubQ at week 0, 2 and 4 Qty: 6 syringes Refills: 0 Maintenance: <input type="checkbox"/> 2 x 200 mg SubQ every 4 weeks <input type="checkbox"/> 2 x 200 mg SubQ every 2 weeks <input type="checkbox"/> 200 mg SubQ every 2 weeks Qty: 28 days Refills: _____</p> <p>COSENTYX® (secukinumab) <input type="checkbox"/> 150 mg Sensoready® Pen Kit <input type="checkbox"/> 75 mg Prefilled Syringe Kit <input type="checkbox"/> 150 mg Prefilled Syringe Kit Induction: <input type="checkbox"/> Inject 300 mg (2 x 150 mg/ml) SubQ week 0, 1, 2, 3, 4 Qty: 10 Refills: 0 <input type="checkbox"/> Inject 150 mg SubQ week 0, 1, 2, 3, 4 Qty: 5 Refills: _____ Maintenance: <input type="checkbox"/> Inject 300 mg SubQ every 4 weeks <input type="checkbox"/> Inject 150 mg SubQ every 4 weeks Qty: 28 days Refills: _____ <input type="checkbox"/> Bridge*</p> <p>DUPIXENT® (dupilumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Induction: Inject 2 x 300 mg (600 mg) SubQ Day 1 Qty: 2 for 14 days Refills: None <input type="checkbox"/> Maintenance: Inject 300 mg SubQ every other week Qty: 2 for 28 days Refills: _____</p> <p>ENBREL® (etanercept) <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Vial <input type="checkbox"/> Induction: Inject (50 mg) SubQ twice weekly for three months Qty: 8 Refills: 2 Maintenance: <input type="checkbox"/> 50 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> Once weekly SubQ <input type="checkbox"/> Twice weekly SubQ Qty: <input type="checkbox"/> 8 <input type="checkbox"/> 4 Refills: _____</p> <p><input type="checkbox"/> OTHER STRENGTH: _____</p>	<p>HUMIRA® (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Original Formula Hidradenitis Suppurativa Starter: <input type="checkbox"/> 160 mg SubQ day 1/ 80 mg SubQ day 15 <input type="checkbox"/> 80 mg SubQ day 1/ 80 mg SubQ day 2/ 80 mg SubQ day 15 <input type="checkbox"/> Psoriasis Starter: 80 mg SubQ day 1, 40 mg SubQ day 8, 40 mg SubQ day 22 Qty: 1 Pack Refills: 0 <input type="checkbox"/> Hidradenitis Suppurativa Maintenance: <input type="checkbox"/> 40 mg SubQ once weekly, beginning day 29 <input type="checkbox"/> 80 mg SubQ every other week, beginning day 29 <input type="checkbox"/> Psoriasis Maintenance: 40 mg SubQ every other week Qty: 28 days Refills: _____</p> <p>INFLECTRA® (infliximab-dyyb) 100 mg vials <input type="checkbox"/> 3 mg/ kg <input type="checkbox"/> 5 mg/ kg <input type="checkbox"/> 10 mg/ kg <input type="checkbox"/> Induction: Give dose as an IV infusion at 0, 2, and 6 weeks Qty: _____ Refills: 2 <input type="checkbox"/> Maintenance: Give dose as an IV infusion every ___ weeks Qty: _____ Refills: 2</p> <p>ILUMYA™ (tildrakizumab-asmn) Prefilled Syringe <input type="checkbox"/> Induction: Inject 100 mg/ml SubQ at weeks 0 and 4 Qty: 2 Refills: None <input type="checkbox"/> Maintenance: Inject 100 mg/ml SubQ every 12 weeks Qty: _____ Refills: _____</p> <p>OLUMIANT® (baricitinib) tablets <input type="checkbox"/> 2 mg PO once daily <input type="checkbox"/> 4 mg PO once daily Qty: _____ Refills: _____</p> <p>OTEZLA® (apremilast) <input type="checkbox"/> Titration Pack: PO as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Bridge Pack: PO as directed per package instructions Qty: 1 Pack Refills: _____ <input type="checkbox"/> Maintenance: (30 mg) PO twice daily Qty: 30 days Refills: _____</p> <p>REMICADE® (infliximab) 100 mg vials <input type="checkbox"/> Biosimilar authorized <input type="checkbox"/> Induction: 5 mg/ kg as an IV infusion at 0, 2, and 6 weeks Qty: 1 dose Refills: 2 <input type="checkbox"/> Maintenance: 5 mg/ kg as an IV infusion every 8 weeks Qty: _____ Refills: _____</p> <p>RINVOQ® (upadacitinib) extended-release tablets <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Once daily PO with or without food Qty: _____ Refills: _____</p>	<p>SIMPONI® (golimumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Inject 50 mg SubQ once a month Qty: 1 Refills: _____</p> <p>SILIQ® (brodalumab) Prefilled Syringe <input type="checkbox"/> Induction: Inject 210 mg SubQ weeks 0 and 1 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: Starting at Week 2 of therapy, inject 210 mg SubQ every two weeks Qty: 2 Refills: _____</p> <p>SKYRIZI™ (risankizumab-rzaa) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Induction: Inject 150 mg(1 injection) SubQ at Week 0, Week 4 Qty: 2 Refills: None <input type="checkbox"/> Maintenance: Inject 150 mg(1 injection) SubQ every 12 weeks Qty: _____ Refills: _____</p> <p>STELARA® (ustekinumab) <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe <input type="checkbox"/> Induction: Inject contents of 1 syringe SubQ on day 0 and day 28 Qty: 1 syringe Refills: 1 <input type="checkbox"/> Maintenance: Inject contents of 1 syringe SubQ every 12 weeks Qty: 1 syringe Refills: _____</p> <p>SOTYKTU™ (deucravacitinib) 6 mg tablet Once daily PO with or without food Qty: _____ Refills: _____</p> <p>TALTZ® CF (ixekizumab) <input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Psoriasis Induction: Inject 160 mg (2 x 80 mg) SubQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8, 10, 12 Qty: 8 Refills: 0 <input type="checkbox"/> Psoriatic Arthritis Induction: Inject 160 mg (2 x 80 mg) SubQ at week 0 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: 80 mg SubQ every 4 weeks Qty: 1 Refills: _____</p> <p>TREMFYA® (guselkumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Induction: Inject 100 mg SubQ weeks 0 and 4 Qty: 1 Refills: 1 <input type="checkbox"/> Maintenance: Inject 100 mg SubQ every 8 weeks Qty: 1 Refills: _____</p>
<p>As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. <input type="checkbox"/> Dispense as written</p>		<p>REFILLS: _____ QUANTITY: _____</p>

PHYSICIAN INFORMATION

Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office	
NPI #:	Tax ID#:	
Prescription Signature:	Date:	