

Dermatology Referral Form A-M

Fax #: 844-635-5250

Patient Information

Patient Name: _____ DOB: _____ SS#: _____ Ship To: Home Clinic
Address: _____ City: _____ State: _____ Zip: _____
Phone(day): _____ Phone (night): _____ Cell: _____
Rx Insurance: _____ Group #: _____ ID #: _____ RX Bin #: _____
Medical Insurance: _____ Group #: _____ ID #: _____ Phone : _____

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 L20. __ Atopic Dermatitis

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: _____

Current Medication: _____

Medication

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

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

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 _____

Erivedge 150mg _____ Take one capsule by mouth daily 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 on day 8, then 40mg every other week

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) Quantity # 1 Refills 0
80mg SQ on day 15

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 _____

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Phone: _____ Fax: _____

Address: _____ Nurse: _____ Date: _____

Physician Signature: _____