Dermatology Referral Form N-Z

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 ☐ Other: ________________

2. **Drug Allergies:** ____

3. **Failed Medications: (When)** ☐ Soriatane _______________ ☐ MTX ____________ ☐ Biologics ____________________ ☐ 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

Odomzo 200mg
__ Take one capsule by mouth on an empty stomach, One hour before or two hours after a meal — Quantity: 30 day supply — Refills _____

Otezla
__ Starter Pack — __ Take 1 tablet on day 1 then twice daily as directed — Quantity # 1 Pack
__ 30 mg Tablets — __ Take 1 tablet by mouth twice daily — Quantity # 60 — Refills _____

Siliq 210mg
__ Load: Inject 210mg SQ at weeks 0,1, and 2 and then Every two weeks. — Quantity: #4 syringes — Refills: 0
__ Maintenance: Inject 210mg SQ every 2 weeks — Quantity:#2 syringes — Refills: ____

Simponi 50mg — Inject 50mg SC once a month as directed
___ 50mg Smartject — Quantity # _____ — Refills ______
___ 50mg Prefilled Syringe

Skyrizi 75mg PFS
__ Load: Inject 150mg SQ on week 0 — Quantity # 2 syringes — Refills: 0
__ Maintenance: Inject 150mg on week 4, then every 12 weeks — Quantity # 2 syringes — Refills: _____

Stelara 45mg _____ — Inject _____ mg on day 1, then week 4, then every 12 weeks
Stelara 90mg _____ — Quantity # _____ — Refills _____

Taltz 80mg/ml __ AutoInjector __ Prefilled Syringe
__Load: Inject 160mg SQ on week 0, then 80mg week 2, — Quantity: #3 — Refills: 0
then 80mg on weeks 4,6,8,10, then — Quantity: #2 — Refills: 1
Inject 80 mg at week 12 — Quantity: #1 — Refills: 0
__Load (Psoriatic Arthritis): Inject 160mg SQ on day 1 — Quantity: #2 — Refills: 0
__ Maintenance: Inject 80mg SQ every 4 weeks — Quantity: #1 — 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: __________________________________