# Dermatology A-G Referral Form

**Date:**

## 1.)Patient Information *(Please provide front and back copy of patient's prescription insurance card)*

| | | | | | |
|---|---|---|---|---|---|
| Name: | | Date of Birth: | Sex: M F | Height: | Weight: lbs |
| Address: | APT/STE: | City: | State: | Zip: | |
| Phone Number: | | Alt. Phone Number: | SS#: | | |
| Text Messages? Y N | **Ship to: Patient Provider** | E-Mail Address: | | | |
| Insurance Plan: | ID #: | Bin: | PCN: | RX Group: | |

## 2.)Provider Information

| | | | | |
|---|---|---|---|---|
| Office Name: | | Provider Name: | | |
| Address: | APT/STE: | City: | State: | Zip: |
| Phone Number: | | Fax Number: | | |
| NPI: | Tax ID: | Provider Type: MD DO NP PA-C Other: | | |

## 3.)Clinical Information *(please fax all applicable office notes & labs)*

| Previous Therapy | Not Tolerated | Tried & Failed Duration | Contraindication | Previous Therapy | Not Tolerated | Tried & Failed Duration | Contraindication |
|---|---|---|---|---|---|---|---|
| MTX | | | | Simponi | | | |
| Cyclosporine | | | | Stelara | | | |
| Sulfasalazine | | | | Enbrel | | | |
| Acitretin | | | | Taltz | | | |
| Humira | | | | Hydrocortisone | | | |
| Cimzia | | | | Clobetasol | | | |
| Cosentyx | | | | PUVA/UVB | | | |
| | | | | | | | |
| | | | | | | | |

**Additional Clinical Information**

Latex Allergy: **Yes No**

TB Test: **Yes No**

Date: Result:

Hepatitis B Ruled Out?

**Yes No Date:**

Loading dose taken of medication below?

**Yes No Date:**

PGA Score: 0 1 2 3 4 5

Additional Tried & Failed Medications/Additional Details:

Affected Area(s): Hands Arms Trunk Feet Legs Scalp Groin Nails Other:

BSA %: PASI Score:

Diagnosis: Diagnosis Date:

- L20.9 Atopic Dermatitis
- L40.0 Plaque Psoriasis
- L40.5 Psoriatic Arthritis
- L40.8 Other Psoriasis
- L73.2 Hidradenitis S.
- Other:

**Comorbidities:** **Allergies:** NKDA

Shade affected areas:

## 4.)Medications

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| **Cimzia** | 200mg/mL PFS | **Loading Dose:** Inject 400mg SQ at weeks 0, 2, and 4<br>Patient Weight:___________lbs | 6x200mg PFS | 0 |
| | | Inject 400mg SQ every other week<br>PsO (<90kg) or PsA: Inject 200mg SQ every 2 weeks<br>PsA #2: Inject 400mg SQ once every 4 weeks | 2x200mg PFS<br>4x200mg PFS | |
| **Cosentyx** | 150mg/mL<br>PFS Pens | **Loading Dose:** Inject 150mg SQ at weeks 0, 1 , 2 ,3 , & 4 | 5 | 0 |
| | | **Loading Dose:** Inject 300mg SQ at weeks 0, 1 , 2 ,3 , & 4 | 10 | 0 |
| | | **Maintenance Dose:** Inject 150mg SQ every 4 weeks<br>**Maintenance Dose:** Inject 300mg SQ every 4 weeks | 4 Week Supply | |
| **Dupixent** | 300mg/2mL PFS | **Loading Dose:** Inject 600mg SQ on day 1, then 300mg SQ every other week starting day 15 | 4 PFS | 0 |
| | | **Maintenance Dose:** Inject 300mg SQ every other week | 4 Week Supply | |
| **Enbrel** | 50mg/ML<br>Mini PFS Sureclick | **PsO Loading Dose:** Inject 50mg SQ twice weekly for 3 months | 4 Week Supply | 2 |
| | | **PsA & PsO Maintenance Dose:** Inject 50mg SQ once weekly | 4 Week Supply | |

## 5.)Provider's Signature

Substitution Permissible

Dispense As Written



With your signature, you are authorizing the pharmacy and its' representatives to act as agents in initiation and follow up of the prior authorization process.