Dermatology S-Z 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
MTX			
Cyclosporine			
Sulfasalazine			
Acitretin			
Humira			
Cimzia			
Cosentyx			

Previous Therapy	Not Tolerated	Tried & Failed Duration	Contraindication
Simponi			
Stelara			
Enbrel			
Taltz			
Hydrocortisone			
Clobetasol			
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

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

BSA %: _____ PASI Score: _____

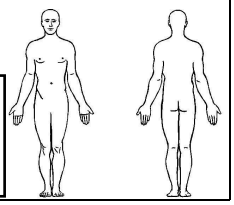
Diagnosis: Diagnosis Date: _____

- ☐ 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:



Additional Tried & Failed Medications/Additional Details:

4.)Medications

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Siliq	210mg/1.5mL PFS	☐ **Loading Dose:** Inject 210mg SQ at weeks 0 & 1	2 Syringes	0
		☐ **Maintenance:** Inject 210mg SQ every 2 weeks starting at week 2	2 Syringes	
☐ Stelara Patient weight:_____lbs	☐ 45mg/0.5mL PFS **wt. ≤ 220lbs** ☐ 90mg/mL PFS **wt. > 220 lbs**	☐ **Loading Dose:** Inject 1 syringe SQ on Week 0	1	0
		☐ **Maintenance:** Inject 1 syringe SQ on week 4 and every 12 weeks after	1	
☐ Taltz	☐ 80mg/mL Autoinjector ☐ 80mg/mL PFS	☐ **Loading Dose:** Inject 160mg SQ on week 0 then 80mg on week 2 then Inject 80mg SQ every 2 weeks starting week 4 (weeks 4, 6, 8, 10) Inject 80mg SQ at week 12	3 2 1	0 1 0
		☐ **Loading (PSO):** Inject 160mg SQ on day 1	2	0
		☐ **Maintenance:** Inject 80mg SQ every 4 weeks thereafter	1	
☐ Tremfya	100mg/mL Pre-Filled Syringe	☐ **Initial:** Inject 100mg SQ on day 1	1	0
		☐ **Maintenance:** Inject 100mg SQ on day 29 and every 8 weeks thereafter	1	
☐ Other:				
☐ Other:				

5.)Provider's Signature

_____ Substitution Permissible

_____ Dispense As Written