

Dermatology Referral Form



Prescriber's Name: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_

Date: \_\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office  Other: \_\_\_\_\_

**PATIENT INFORMATION:** Please complete the following or send patient demographic sheet.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

**PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION**

**CLINICAL INFORMATION:** Please send recent clinical notes, current medications, labs, and tests to expedite the **Prior Authorization**.

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Prior Failed Medications: \_\_\_\_\_  Treatment-naive  
 Duration and Reason for D/C: \_\_\_\_\_ Does the patient have a latex allergy?  Yes  No TB/PPD Test given?  Yes  No  
 Methotrexate contraindicated:  Elderly or Disabled  Pregnancy/Breastfeeding  Social activities  Patient is of child bearing age  Chronic Liver Disease  
 Comments: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication	Strength	Directions/SIG	Quantity	Refill
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150 mg/mL Sensoready Pen <input type="checkbox"/> 150 mg/mL Prefilled Syringe	<b>Plaque Psoriasis/Arthritis Starter Dose:</b> <input type="checkbox"/> Inject two 150 mg pens/syringes SC every week 0, 1, 2, 3, 4 (NO REFILLS) <b>Plaque Psoriasis/Arthritis Maintenance Dose:</b> <input type="checkbox"/> Inject two 150 mg pens/syringes SC every 4 weeks	5 Kits	X
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 300 mg/2 mL Prefilled Syringe	<b>Starter Dose:</b> <input type="checkbox"/> Inject two 300 mg/2ml syringes (NO REFILLS) <b>Maintenance Dose:</b> <input type="checkbox"/> Inject one 300 mg/2ml syringe every other week		X
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50 mg/mL Sureclick Autoinjector <input type="checkbox"/> 50 mg/mL Prefilled Syringe	<b>Psoriasis Induction Dose:</b> <input type="checkbox"/> Inject 50 mg SC 2x/week (3-4 days apart) for 3 months, then start maintenance dosing <b>Psoriasis Maintenance Dose:</b> <input type="checkbox"/> Inject 50 mg SC 1x/week	8	2
<input type="checkbox"/> Humira	<input type="checkbox"/> Psoriasis/Uveitis Starter Package <input type="checkbox"/> Hidradenitis Suppurativa (H.S.) Starter Package <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe	<b>Psoriasis/Uveitis Induction Dose:</b> <input type="checkbox"/> Inject two 40mg pens/syringes SC on day 1, then one 40mg pens/syringes on day 8, then one 40mg pens/syringes every other week (NO REFILLS) <b>Psoriasis/Uveitis Maintenance Dose:</b> <input type="checkbox"/> Inject one 40 mg pen/syringe SC every other week	4	X
		<b>Hidradenitis Suppurativa Induction Dose:</b> <input type="checkbox"/> Inject four 40 mg pens/syringes SC on day 1, then two 40 mg pens/syringes on day 15, then one 40mg pens/syringes every week starting day 29 (NO REFILLS)	4	X
		<b>Hidradenitis Suppurativa Induction ALT Dose:</b> <input type="checkbox"/> Inject two 40 mg pens/syringes SC on day 1, 2, 15, and then on day 29, one 40 mg pen every week (NO REFILLS) <b>Hidradenitis Suppurativa Maintenance Dose:</b> <input type="checkbox"/> Inject one 40 mg pen/syringe SC every week	4	X
<input type="checkbox"/> Humira Citrate Free	<b>Citrate Free</b> Starting Therapy <b>Psoriasis/Uveitis Starter Package</b> <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 80 mg/0.8 mL Pen <input type="checkbox"/> <b>Hidradenitis Suppurativa (H.S.) Starter Package</b> 80 mg/0.8 mL Pen <b>Maintenance</b> <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe	<b>Psoriasis Psoriasis Citrate Free Induction Dose:</b> <input type="checkbox"/> Inject two 40 mg pens SC on day 1, then inject one 40 mg pen SC on day 8, then inject one 40 mg pen SC on day 22 or <input type="checkbox"/> One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 <b>Psoriasis Citrate Free Maintenance Dose:</b> <input type="checkbox"/> Inject one 40 mg pen/syringe SC every other week	<input type="checkbox"/> 3 Pens <input type="checkbox"/> 4 Syringes	
		<b>Hidradenitis Suppurativa Citrate Free Induction Dose:</b> <input type="checkbox"/> Inject two 80 mg pen SC on day 1, then inject one 80 mg pen SC on day 15 or <input type="checkbox"/> One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15 <b>Hidradenitis Suppurativa Citrate Free Maintenance Dose:</b> <input type="checkbox"/> Inject one 40 mg pen/syringe SC day 29 & every other week	3	No Refills
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg/0.5 mL Prefilled Syringe	<b>Induction Dose:</b> For patients weighing < 100 kg (220 lbs): Inject 45 mg SC on day 1 (NO REFILLS) <b>Maintenance Dose:</b> For patients weighing < 100 kg (220 lbs): Inject 45 mg SC on day 29, then every 12 weeks	1	X
	<input type="checkbox"/> 90 mg/mL Prefilled Syringe	<b>Induction Dose:</b> For patients weighing > 100 kg (220 lbs): Inject 90 mg SC on day 1 (NO REFILLS) <b>Maintenance Dose:</b> For patients weighing > 100 kg (220 lbs) Inject 90 mg SC on day 29, then every 12 weeks	1	X
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/1 mL Prefilled Syringe	<b>Psoriatic Arthritis Dose:</b> <input type="checkbox"/> Inject SC one 100 mg injections at week 0 & week 4 then every 8 weeks thereafter		
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack (4-week supply)	<b>Starter Dose:</b> Day 1: 10 mg in AM Day 3: 10 mg PO in AM & 20 mg PO in PM Day 5: 20 mg PO in AM & 30 mg PO in PM Day 2: 10 mg PO in AM & 10 mg PO in PM Day 4: 20 mg PO in AM & 20 mg PO in PM Day 6+: 30 mg PO TWICE daily	55 (28 Day Supply)	X
	<input type="checkbox"/> 30mg tablet	<b>Maintenance Dose:</b> 1 tablet twice daily <b>Maintenance Dose (severe renal impairment):</b> Take 30 mg PO ONCE daily		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		

**Quality Specialty Pharmacy**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.