

# Dermatology Referral Form

## PATIENT INFORMATION

Patient's Name:			SSN:	DOB:	
Address:			City:	State:	Zip:
Home Phone:	Cell:	Email:	Height:	Weight:	Gender: Male Female

## INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

## CLINICAL INFORMATION

**Primary Diagnosis:**  Moderate to Severe Plaque Psoriasis  Psoriatic Arthritis  Hidradenitis Suppurativa  Atopic Dermatitis  Alopecia Areata  Other: \_\_\_\_\_ **Diagnosis Code (ICD-10):** \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ TB Test Completed On: \_\_\_\_\_ BSA: \_\_\_\_\_ Latex Allergy: Y N

## PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

<p><b>ADBRY™ (tralokinumab-ldrm)</b> 150 mg Prefilled Syringe  <input type="checkbox"/> Induction: Inject 600 mg (4 x150 mg) SubQ  <b>Qty:</b> 4 <b>Refills:</b> None  <b>Maintenance:</b>  <input type="checkbox"/> Inject 300 mg (2 x150 mg) SubQ every other week  <input type="checkbox"/> Inject 300 mg (2 x150 mg) SubQ every 4 weeks  <input type="checkbox"/> <b>ADBRY™ Bridge Care™</b> Program:          Inject 300 mg (2 x 150 mg) SubQ every other week starting on Day 15  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>AMJEVITA™ (adalimumab-atto)</b> Prefilled Syringe  <input type="checkbox"/> SureClick 40 mg/0.8 mL <input type="checkbox"/> PFS 20 mg/0.4 mL  <input type="checkbox"/> PFS 40 mg/0.8 mL  <input type="checkbox"/> Induction: Inject 2 x 40 mg SubQ  <input type="checkbox"/> <b>Maintenance:</b> 40 mg every other week starting one week after initial dose  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>CIBINQO™ (abrocitinib)</b> Tablet  <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg _____ mg PO once daily  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>Cimzia® (certolizumab pegol)</b> Prefilled Syringe  <input type="checkbox"/> Induction: Inject 2 x 200 mg/ml SubQ at week 0, 2, and 4  <b>Qty:</b> 6 syringes <b>Refills:</b> 0  <b>Maintenance:</b>  <input type="checkbox"/> 2 x 200 mg SubQ every 4 weeks  <input type="checkbox"/> 2 x 200 mg SubQ every 2 weeks  <input type="checkbox"/> 200 mg SubQ every 2 weeks  <b>Qty:</b> 28 days <b>Refills:</b> _____</p> <p><b>COSENTYX® (secukinumab)</b>  <b>75 mg</b> <input type="checkbox"/> 75 mg PFS  <input type="checkbox"/> Induction: Inject 75 mg SubQ at weeks 0, 1, 2, 3  <b>Qty:</b> 28 days <b>Refills:</b> 0  <input type="checkbox"/> <b>Maintenance:</b> Inject 75 mg SubQ on week 4, then every 4 weeks  <b>Qty:</b> 28 days <b>Refills:</b> _____</p> <p><b>150 mg</b> <input type="checkbox"/> 150 mg Sensoready® Pen Kit <input type="checkbox"/> 150 mg PFS  <input type="checkbox"/> Induction: Inject 150 mg SubQ at weeks 0, 1, 2, 3  <b>Qty:</b> 5 <b>Refills:</b> _____  <input type="checkbox"/> <b>Maintenance:</b> Inject 150 mg SubQ on week 4, then every 4 weeks  <b>Qty:</b> 28 days <b>Refills:</b> _____</p> <p><b>300 mg</b> <input type="checkbox"/> UnoReady Pen (1 x 300 mg/2ml)  <input type="checkbox"/> Sensoready® Pen Kit (2 x 150 ml) <input type="checkbox"/> PFS (2x 150 ml)  <input type="checkbox"/> Induction: Inject 300 mg SubQ wat weeks 0, 1, 2, 3  <b>Qty:</b> 28 days <b>Refills:</b> 0  <input type="checkbox"/> <b>Maintenance:</b> Inject 300 mg SubQ on week 4, then every 4 weeks  <b>Qty:</b> 28 days <b>Refills:</b> _____  <input type="checkbox"/> <b>Bridge™</b></p> <p><b>DUPIXENT® (dupilumab)</b> <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen  <input type="checkbox"/> Induction: Inject 2 x 300 mg (600 mg) SubQ Day 1  <b>Qty:</b> 2 for 14 days <b>Refills:</b> None  <input type="checkbox"/> <b>Maintenance:</b> Inject 300 mg SubQ every other week  <b>Qty:</b> 2 for 28 days <b>Refills:</b> _____</p>	<p><b>ENBREL® (etanercept)</b>  <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> PFS <input type="checkbox"/> Autolinjector <input type="checkbox"/> Vial  <input type="checkbox"/> Induction: Inject (50 mg) SubQ twice weekly for three months  <b>Qty:</b> 8 <b>Refills:</b> 2  <b>Maintenance:</b> <input type="checkbox"/> 50 mg <input type="checkbox"/> 25 mg  <input type="checkbox"/> Once weekly SubQ <input type="checkbox"/> Twice weekly SubQ  <b>Qty:</b> <input type="checkbox"/> 8 <input type="checkbox"/> 4 <b>Refills:</b> _____</p> <p><b>ERIVEDGE™ (vismodegib)</b> capsule 150 mg Once daily PO with or without food  <b>Qty:</b> 28 days <b>Refills:</b> _____</p> <p><b>HUMIRA® (adalimumab)</b>  <input type="checkbox"/> Pen <input type="checkbox"/> PFS  <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Original Formula  <b>Hidradenitis Suppurativa Starter:</b>  <input type="checkbox"/> 160 mg SubQ day 1/ 80 mg SubQ day 15  <input type="checkbox"/> 80 mg SubQ day 1/ 80 mg SubQ day 2/ 80 mg SubQ day 15  <input type="checkbox"/> <b>Psoriasis Starter:</b> 80 mg SubQ day 1, 40 mg SubQ day 8, 40 mg SubQ day 22  <b>Qty:</b> 1 Pack <b>Refills:</b> 0  <input type="checkbox"/> <b>Hidradenitis Suppurativa Maintenance:</b>  <input type="checkbox"/> 40 mg SubQ once weekly, beginning day 29  <input type="checkbox"/> 80 mg SubQ every other week, beginning day 29  <input type="checkbox"/> <b>Psoriasis Maintenance:</b> 40 mg SubQ every other week  <b>Qty:</b> 28 days <b>Refills:</b> _____</p> <p><b>INFLECTRA® (infliximab-dyyb)</b> 100 mg vials  <input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg  <input type="checkbox"/> Induction: Give dose as an IV infusion at 0, 2, and 6 weeks  <b>Qty:</b> _____ <b>Refills:</b> 2  <input type="checkbox"/> <b>Maintenance:</b> Give dose as an IV infusion every _____ weeks  <b>Qty:</b> _____ <b>Refills:</b> 2</p> <p><b>ILUMIYA™ (tildrakizumab-asmn)</b> Prefilled Syringe  <input type="checkbox"/> Induction: Inject 100 mg/ml SubQ at weeks 0 and 4  <b>Qty:</b> 2 <b>Refills:</b> None  <input type="checkbox"/> <b>Maintenance:</b> Inject 100 mg/ml SubQ every 12 weeks  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>LITFULO™ (ritlecinib)</b> capsule <input type="checkbox"/> 50 mg by mouth once daily  <b>Qty:</b> 28 <b>Refills:</b> _____</p> <p><b>ODOMZO® (sonidegib)</b> capsule 200 mg on an empty stomach, at least 1 hr before or 2 hrs after a meal  <b>Qty:</b> 30 <b>Refills:</b> _____</p> <p><b>OLUMIANT® (baricitinib)</b> tablets  <input type="checkbox"/> 2 mg PO once daily <input type="checkbox"/> 4 mg PO once daily  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>OTEZLA® (apremilast)</b>  <input type="checkbox"/> Titration Pack: PO as directed per package instructions  <b>Qty:</b> 1 Pack <b>Refills:</b> 0  <input type="checkbox"/> <b>Bridge Pack:</b> PO as directed per package instructions  <b>Qty:</b> 1 Pack <b>Refills:</b> _____  <input type="checkbox"/> <b>Maintenance:</b> (30 mg) PO twice daily  <b>Qty:</b> 30 days <b>Refills:</b> _____</p>	<p><b>REMICADE® (infliximab)</b> 100 mg vials <input type="checkbox"/> Biosimilar authorized  <input type="checkbox"/> Induction: 5 mg/kg as an IV infusion at 0, 2, and 6 weeks  <b>Qty:</b> 1 dose <b>Refills:</b> 2  <input type="checkbox"/> <b>Maintenance:</b> 5 mg/kg as an IV infusion every 8 weeks  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>RINVOQ® (upadacitinib)</b> extended-release tablets  <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg          Once daily PO with or without food  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>SIMPONI® (golimumab)</b>  <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector  <input type="checkbox"/> Inject 50 mg SubQ once a month  <b>Qty:</b> 1 <b>Refills:</b> _____</p> <p><b>SILIQ® (brodalumab)</b> Prefilled Syringe  <input type="checkbox"/> Induction: Inject 210 mg SubQ weeks 0 and 1  <b>Qty:</b> 2 <b>Refills:</b> 0  <input type="checkbox"/> <b>Maintenance:</b> Starting at Week 2 of therapy, inject 210 mg SubQ every 2 weeks  <b>Qty:</b> 2 <b>Refills:</b> _____</p> <p><b>SKYRIZI™ (risankizumab-rzaa)</b>  <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen  <input type="checkbox"/> Inject 150 mg (1 injection) SubQ at Week 0, Week 4  <b>Qty:</b> 2 syringes <b>Refills:</b> _____  <input type="checkbox"/> <b>Maintenance:</b> Inject 150 mg SubQ every 12 weeks  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>STELARA® (ustekinumab)</b>  <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe  <input type="checkbox"/> Induction: Inject contents of 1 syringe SubQ on day 0 and day 28  <b>Qty:</b> 1 syringe <b>Refills:</b> 1  <input type="checkbox"/> <b>Maintenance:</b> Inject contents of 1 syringe SubQ every 12 weeks  <b>Qty:</b> 1 syringe <b>Refills:</b> _____</p> <p><b>SOTYKTU™ (deucravacitinib)</b> 6 mg tablet          Once daily PO with or without food  <b>Qty:</b> _____ <b>Refills:</b> _____</p> <p><b>TALTZ® (ixekizumab)</b>  <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Autolinjector <input type="checkbox"/> Prefilled Syringe  <input type="checkbox"/> <b>Psoriasis Induction:</b> Inject 160 mg (2 x 80 mg) SubQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8, 10, 12  <b>Qty:</b> 8 <b>Refills:</b> 0  <input type="checkbox"/> <b>Psoriatic Arthritis Induction:</b> Inject 160 mg (2 x 80 mg) SubQ at week 0  <b>Qty:</b> 2 <b>Refills:</b> 0  <input type="checkbox"/> <b>Maintenance:</b> 80 mg SubQ every 4 weeks  <b>Qty:</b> 1 <b>Refills:</b> _____</p> <p><b>TREMFYA® (guselkumab)</b>  <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector  <input type="checkbox"/> Induction: Inject 100 mg SubQ weeks 0 and 4  <b>Qty:</b> 1 <b>Refills:</b> 1  <input type="checkbox"/> <b>Maintenance:</b> Inject 100 mg SubQ every 8 weeks  <b>Qty:</b> 1 <b>Refills:</b> _____</p>	
<input type="checkbox"/> <b>OTHER</b> <b>STRENGTH:</b> _____	<b>SIG/DIRECTIONS:</b> _____	<b>QUANTITY:</b> _____	<b>REFILLS:</b> _____

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

## PHYSICIAN INFORMATION

**Injection Training:**  Office to Instruct  SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office	
NPI #:	Tax ID#:	
Prescription Signature:	Date:	