

# DERMATOLOGY REFERRAL FORM

# 0-Z

Phone (888) 370.1724 Fax (877) 645.7514  
10004 S. 152nd St, Suite A, Omaha NE 68138



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information		
Last Name	First Name	DOB				Practice/Facility Name		
Address						Address		
City	State	ZIP				City	State	ZIP
Phone	SSN					Prescriber Name		
Allergies			Latex Allergy Yes No			Prescriber NPI		
Sex Male Female	Weight (kg)	Height (ft,in)				Nurse/Key Contact		Phone/Pager
Insurance Plan		Plan ID #				Fax		Email

Diagnosis/Clinical Information			PLEASE FAX CLINICAL AND LAB INFORMATION		
Diagnosis:	L20.____ Atopic Dermatitis	L40.0 Psoriasis vulgaris/Plaque psoriasis/Nummular psoriasis	L40.8 Other psoriasis		
	L40.9 Psoriasis, unspecified	L40.5____ Psoriatic arthritis	L73.2 Hidradenitis Suppurativa	Other: _____	
Date of diagnosis or years with the disease: _____					
Active TB is ruled out: Yes No Date of negative TB test: ____/____/____					
Concomitant medications: _____					
Previous treatment regimens with dates and reason for discontinuation: _____					

Prescription Information				
MEDICATION		DOSE/STRENGTH/DIRECTIONS FOR USE	QTY	REFILLS
Otezla®	28-day starter pack	Titration dose: Take as directed per package instructions	55 tablets	0
	Tablets	Bridge dose: Take 30mg by mouth once daily Bridge dose: Take 30mg by mouth twice daily	28	_____
		Maintenance dose: Take 30mg by mouth once daily Maintenance dose: Take 30mg by mouth twice daily	30-day supply	_____
Remicade® Weight ____kg Biosimilars: Inflectra® Renflexis®	Vial	Starter dose: 5mg/kg (____mg) IV at weeks 0, 2 and 6	QS	0
		Maintenance dose: 5mg/kg(____mg) IV every 8 weeks	56 day	_____
Siliq®	PFS	Starter dose: Inject 210mg SC on weeks 0, 1 and 2, inject 210mg SC every 2 weeks thereafter	4 x 210mg/1.5ml	0
		Maintenance dose: Inject 210mg SC every 2 weeks	2 x 210mg/1.5ml	_____
Simponi®	SmartJect Autoinjector PFS	Inject 50mg SC once a month	1 x 50mg/0.5ml	_____
Stelara® Weight ____kg	PFS	Starter dose: Inject 45mg SC on Day 1 (≤100 kg)	1 x 45mg/0.5ml	0
		Starter dose: Inject 90mg SC on Day 1 (>100 kg)	1 x 90mg/ml	_____
		Maintenance dose: Inject 45mg SC on Day 29 and every 12 weeks thereafter (≤100 kg) Maintenance dose: Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100 kg)	1 x 45mg/0.5ml 1 x 90mg/ml	_____
Taltz®	Autoinjector PFS	Starter dose: Inject 160mg (2 x 80mg) SC at week 0, then inject 80mg SC at week 2	3 x 80mg/ml	0
	Autoinjector PFS	Starter dose: Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	4 x 80mg/ml	0
	Autoinjector PFS	Maintenance dose: Inject 80mg SC at week 12 and every 4 weeks thereafter	1 x 80mg/ml	_____
Tremfya®	PFS	Starter dose: Inject 100mg SC at week 0, then 100mg at week 4 and every 8 weeks thereafter	2 x 100mg/ml	0
		Maintenance dose: Inject 100mg SC every 8 weeks	1 x 100mg/ml	_____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PREScriBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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