

DERMATOLOGY REFERRAL FORM

A-H

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
Cimzia® PFS Vials	Starter dose: Inject 400mg SC at weeks 0, 2 and 4	6 x 200mg/ml	0
	Maintenance dose: Inject 200mg SC every 2 weeks Maintenance dose: Inject 400mg SC every 4 weeks	2 x 200mg/ml	_____
Cosentyx® Sensoready Pen PFS	Starter dose: Inject 150mg SC once weekly at weeks 0, 1, 2 and 3 Starter dose: Inject 300mg SC once weekly at weeks 0, 1, 2 and 3	4 x 150mg/ml 8 x 150mg/ml	0
	Maintenance dose: Inject 150mg SC on week 4 and every 4 weeks thereafter Maintenance dose: Inject 300mg SC on week 4 and every 4 weeks thereafter	1 x 150mg/ml 2 x 150mg/ml	_____
Dupixent® PFS	Starter dose: Inject 600mg SC on day 1, followed by 300mg SC at day 15 and every 2 weeks thereafter	4 x 300mg/2ml	0
	Maintenance dose: Inject 300mg SC every 2 weeks	2 x 300mg/2ml	_____
Enbrel® Adult	SureClick Autoinjector PFS Enbrel® Mini	Starter dose: Inject 50mg SC twice a week (72-96 hours apart) for 3 months	8 x 50mg/ml
		Maintenance dose: Inject 50mg SC every week	4 x 50mg/ml
Enbrel® Pediatric ≥4yo Weight _____kg	Vials PFS	Inject _____mg (0.8mg/kg) SC every week (<63 kg)	_____ x 25mg
	SureClick Autoinjector PFS Enbrel® Mini	Inject 50mg SC every week (≥63kg)	4 x 50mg
Humira® Pens PFS	Plaque psoriasis (starter dose): Inject 80mg SC day 1, then 40mg SC on day 8, then 40mg every 2 weeks	4 x 40mg/0.8ml	0
	Hidradenitis Suppurativa (starter dose): Inject 160mg SC on day 1, then 80mg on day 15 then 40mg SC on day 29 and every week thereafter	6 x 40mg/0.8ml	
Humira® Induction Dose (Citrate-Free)	Plaque psoriasis (starter dose): Inject 80mg SC day 1, then 40mg SC on day 8, then 40mg every 2 weeks	1 KIT of 1 x 80mg/0.8mL, 2 x 40mg/0.4mL	0
	Hidradenitis Suppurativa (starter dose): Inject 160mg SC on day 1, 80mg on day 15, then 40mg SC on day 29 and every week thereafter	1 KIT of 3 x 80mg/0.8mL	0
Humira® MAINTENANCE DOSE	40mg/0.8mL Pen 40mg/0.8mL PFS 40mg/0.4mL Pen (Citrate-free) 40mg/0.4mL PFS (Citrate-free)	Plaque Psoriasis (maintenance dose) 40mg SC injection EVERY OTHER week Hidradenitis Suppurativa (maintenance dose) 40mg SC injection EVERY week Other: _____	#2 #4 # _____

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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