

# Dermatology Referral Form

Surescripts ID #:

Office #: 1-210-881-0890

Fax #: 1-210-569-6464

## PATIENT INFORMATION

PATIENT NAME		SSN #:		DOB:	
ADDRESS:		CITY:		STATE:	
HOME PHONE:		CELL PHONE:		ZIP:	
Email ADDRESS:		HEIGHT:		WEIGHT:	
		GENDER: MALE FEMALE			
		DIAGNOSIS CODE:			

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

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

## PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

**To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:**

<table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> CIMZIA®</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> COSENTYX®</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> BRIDGE* <input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> DUPIXENT</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> ENBREL®</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> HUMIRA® CITRATE-FREE</td> <td><input type="checkbox"/> STARTER PACK</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> HUMIRA®</td> <td><input type="checkbox"/> STARTER PACK</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> OTEZLA®</td> <td><input type="checkbox"/> TITRATION PACK</td> <td><input type="checkbox"/> BRIDGE <input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> STELARA®</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> SIMPONI®</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> TALTZ®</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> SILIQ™</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> TREMFYA™</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> <tr> <td><input type="checkbox"/> ILUMYA™</td> <td><input type="checkbox"/> INDUCTION</td> <td><input type="checkbox"/> MAINTENANCE</td> </tr> </table> <p><small>*Covered Until You're Covered Program</small></p>	<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> COSENTYX®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> BRIDGE* <input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> DUPIXENT	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> ENBREL®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> HUMIRA® CITRATE-FREE	<input type="checkbox"/> STARTER PACK	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> STARTER PACK	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> TITRATION PACK	<input type="checkbox"/> BRIDGE <input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> STELARA®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> TALTZ®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> SILIQ™	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> TREMFYA™	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> ILUMYA™	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE	<p><input type="radio"/> Moderate to Severe Plaque Psoriasis      <input type="radio"/> Psoriatic Arthritis</p> <p><input type="radio"/> Hidradentis Suppurativa      <input type="radio"/> Atopic Dermatitis</p> <p><input type="radio"/> Other: _____ Date of Diagnosis: _____</p> <p><small>***Please use this section for additional directions or other medications not listed.***</small></p> <p><b>OTHER</b></p> <hr/> <p><b>STRENGTH:</b></p>
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE																																						
<input type="checkbox"/> COSENTYX®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> BRIDGE* <input type="checkbox"/> MAINTENANCE																																						
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<input type="checkbox"/> ILUMYA™	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE																																						

INDUCTION STARTER		MAINTENANCE		SIG/DIRECTIONS	
STRENGTH:		STRENGTH:		QUANTITY:	
SIG/DIRECTIONS		SIG/DIRECTIONS			
<input type="radio"/> AUTOINJECTOR <input type="radio"/> PEN <input type="radio"/> PREFILLED SYRINGE <input type="radio"/> VIAL		<input type="radio"/> AUTOINJECTOR <input type="radio"/> PEN <input type="radio"/> PREFILLED SYRINGE <input type="radio"/> VIAL		Start of Therapy Date:      Special Delivery Instructions:	
QUANTITY:	REFILLS:	QUANTITY:	REFILLS:		

## PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact/Faxed by:		Email:	
NPI#:	TAXID#:	Ship To: <input type="radio"/> Patient <input type="radio"/> MD 1 <sup>ST</sup> Fill Only <input type="radio"/> MD All Orders	
Prescriber Signature:			
ODispense as written		Date	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. \* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber