

Pharmacy Name:		Phone:	
Address:		Fax:	
City/State/Zip:		Email:	

Dermatology Referral Form

Please attach copy of insurance cards (front and back)

Last Name:	First Name:	DOB:	Practice:
Address:		Address:	
City:	State: Zip:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	City: State: Zip:
Phone:	SSN:	Prescriber Name:	

Insurance Information

Insurance Plan:	Insurance Plan:	Prescriber NPI:
Policy #	Policy #	Nurse/Key Contact:
Plan I.D. #	Plan I.D. #	Phone: Fax:
		Email:

Clinical Information - Statement of Medical Necessity

Please attach clinical/progress notes and test results supporting primary diagnosis

Diagnosis: L40.8 Moderate to severe plaque psoriasis L40.50 Psoriatic arthritis L73.2 Hidradenitis suppurativa
 L20.9 Atopic dermatitis Other _____

Severity of condition: Mild (up to 3% BSA) Moderate (3-10% BSA) Severe (>10% BSA) BSA% _____

Location: Hands Feet Scalp Groin Nails Other _____

Prior failed meds: Methotrexate Length of treatment _____ Reason for discontinuing _____
 PUVA/UVB Length of treatment _____ Reason for discontinuing _____
 Topicals Length of treatment _____ Specific meds _____
 Other Length of treatment _____ Specific meds _____

TB/PPD test given? Yes No Positive Negative Date _____ Allergies _____

Treatment location: Home Infusion suite Other _____

Labs

Test	Frequency

Nursing Orders

Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

Prescription Information

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Infliximab	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 75mg 2 PFS kit <input type="checkbox"/> 150mg pen <input type="checkbox"/> 150mg PFS	<input type="checkbox"/> Initial: Inject 150mg subcutaneously on week 0 and 4 <input type="checkbox"/> Maintenance: Inject 150mg subcutaneously every 12 weeks	1 1	0
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg vial	<input type="checkbox"/> (<220 lbs) Inject 45mg on day 0 then week 4, followed by 45mg dose every 12 weeks <input type="checkbox"/> (>220 lbs) Inject 90mg on day 0 then week 4, followed by 90mg dose every 12 weeks	28-day supply	
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg prefilled pen <input type="checkbox"/> 100mg prefilled syringe	<input type="checkbox"/> Initial: Inject 100mg subcutaneously at week 0 and 4 <input type="checkbox"/> Maintenance: Inject 100mg subcutaneously every 8 weeks	2 1	0
<input type="checkbox"/> Other				

I authorize Fannin Infusion Pharmacy and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Fannin Infusion Pharmacy.

Physician Signature: _____
Date: _____

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

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This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

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