DERMATOLOGY REFERRAL FORM

Est. 1927
Silver Rod Specialty Care Pharmacy

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Today's Date Anticipated Start Date

☐ NEW PATIENT ☐ CURRENT PATIENT

PATIENT INFORMATION:

Patient Name _____ DOB_____ Weight_____ ☐ Male ☐ Female
Street Address_____ Apt#_____ City_____ State_____ Zip_____
Daytime Tel_____ Even Tel_____ Cell_____ Email_____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed_____

Insured's Name_____ Relation to Patient_____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card Yes No If Yes, Carrier_____ Tel_____ Fax_____ Policy/Group#_____
Bin#_____ Pcn#_____ RX Group#_____ RXID#_____

PRESCRIBING PHYSICIAN INFORMATION:

Prescriber's Name_____ Office Contact_____
Street Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

CLINICAL INFORMATION:

Has patient been diagnosed with heart failure? ☐ Yes ☐ No
Has patient been diagnosed with lymphoma? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No
Does patient have latex allergy? ☐ Yes ☐ No
Is patient platelet count greater than 52,000 cells/uL? ☐ Yes ☐ No
Weight _____ Height _____
BSA% affected by Psoriasis _____
Comments _____

Previous Medication	Reason for discontinuation
☐ Biologics	
☐ Methotrexate	
☐ Oral Meds	
☐ PUVA or UVB	
☐ Topicals	
☐ Other: _____	

PRESCRIPTION

PLEASE E-SCRIBE & ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Medication	Directions	Quantity	Refills
☐ **COSENTYX® (secukinumab)** ☐ 150mg syringe ☐ 150mg pen	Psoriatic arthritis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks Plaque Psoriasis induction (optional): 300mg subcutaneously at weeks 0, 1, 2, 3, and 4 Plaque Psoriasis maintenance: 300mg subcutaneously every 4 weeks Other : _____		
☐ **DUPIXENT® (dupilumab)** ☐ 300mg/2ml prefilled syringe	Induction: Inject 600mg subcutaneously in 2 different injection sites Maintenance: Inject 300mg subcutaneously every other week Other : _____		
☐ **HUMIRA® (adalimumab)** ☐ 40mg/0.8ml pen ☐ 40mg/0.8ml prefilled syringe ☐ Chron's/UC Starter Kit	Induction: Inject 160mg (4 pens) subcutaneously on day 1, then 80mg (2 pens) on day 15 Maintenance: Inject 40mg (1 injection) subcutaneously every other week Other : _____		
☐ **OTEZLA®** ☐ Starter Pack 30 mg tablet	As directed 30 mg PO TWICE daily		
SIMPONI® (golimumab) 100mg SmartJect 100mg prefilled syringe	Induction: Inject 200mg subcutaneously at week 0, then 100mg at week 2 Maintenance: Inject 100mg subcutaneously every 4 weeks		
STELARA® 45 mg/0.5 mL PFS 90 mg/mL PFS	Inject contents of 1 PFS SQ on day 1 Inject contents of 1 PFS SQ starting day 29 & every 12 weeks thereafter		
OTHER: _____			

PRESCRIBER SIGNATURE: (signature required. NO STAMPS) **DATE:**