

Pharmacy:	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="radio"/> M <input type="radio"/> F
City:	State:	Zip:	
Phone:	SSN#:	Prescriber Name:	
Insurance Information			
Insurance Plan:	Insurance Plan:	Prescriber NPI:	
Policy #:	Policy #:	Nurse/Key Contact:	
Plan #:	Plan #:	Phone:	
		Fax:	Email:

Clinical Information – Statement Of Medical Necessity

Please attach clinical/progress notes, labs, test 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 Results _____ Date _____ Allergies _____

Prescription Information

Medication	Dose/Strength	Directions	Quantity	Refills
Adalimumab	<input type="checkbox"/> Psoriasis starter kit	<input type="checkbox"/> Initial: Inject 80mg SC on day 1, 40mg on day 8, then maintenance dose every other week thereafter	1 starter kit	
	<input type="checkbox"/> 40mg pen <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Maintenance: Inject 40mg SC every other week	28-day supply	
Cimzia	<input type="checkbox"/> 200mg vial kit	<input type="checkbox"/> Initial: Inject 400mg SC at weeks 0, 2 and 4 <input type="checkbox"/> Maintenance: Inject 400mg SC every 2 weeks		
Cosentyx	<input type="checkbox"/> 150mg Sensoready pen	Initial: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC week 0, 1, 2, 3, 4	28-day supply	0
	<input type="checkbox"/> 150mg prefilled syringe	Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC every 4 weeks	28-day supply	
Dupixent	<input type="checkbox"/> 200mg/1.14mL prefilled pen	Adults and pediatric ≥ 60kg: <input type="checkbox"/> 600 mg (two 300 mg injections) followed by 300 mg every 2 weeks	28-day supply	
	<input type="checkbox"/> 200mg/1.14mL prefilled syringe	Pediatric Patients <60kg Body Weight Initial Dose Subsequent Doses <input type="checkbox"/> 5 to less than 15kg 200mg (one 200mg injection) 200mg every 4wks <input type="checkbox"/> 15 to less than 30kg <6yr 300mg (one 300mg injection) 300mg every 4wks <input type="checkbox"/> 15 to less than 30kg ≥ 6yr 600mg (two 300mg injections) 300mg every 4wks <input type="checkbox"/> 30 to less than 60kg 400mg (two 200mg injections) 200mg every 2wks		
Enbrel	<input type="checkbox"/> 50mg SureClick autoinjector	<input type="checkbox"/> Initial: RA/PsA 50mg <input type="checkbox"/> Initial: PsO 50mg twice weekly x 3 months	28-day supply	
	<input type="checkbox"/> 50mg PFS <input type="checkbox"/> 50mg mini	<input type="checkbox"/> Maintenance: 50mg <input type="checkbox"/> Maintenance: ped PsO/JPAs 0.8mg/kg weekly-max 50mg weekly		
Humira HS	<input type="checkbox"/> HS starter Kit <input type="checkbox"/> 40mg pen	<input type="checkbox"/> Initial: Inject 160mg SC on day 1, 80mg on day 15, then 40mg every week beginning on day 29	1 starter kit	
	<input type="checkbox"/> 40mg PFS <input type="checkbox"/> HS starter kit CF	<input type="checkbox"/> Maintenance: (At week 4) Inject 40mg SC weekly	28-day supply	
	<input type="checkbox"/> 40mg CF pen <input type="checkbox"/> 40mg CF PFS	<input type="checkbox"/> Inject 80mg every other week		
Ilumya	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Inject 100mg at weeks 0, 4 and every 12 weeks thereafter		
Infliximab	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks		
Simponi	<input type="checkbox"/> 50mg SmartJect <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SC once a month as directed	28-day supply	
Skyrizi	<input type="checkbox"/> 75mg 2 PFS kit	<input type="checkbox"/> Initial: Inject 150mg SC on week 0 and 4	1	0
	<input type="checkbox"/> 150mg pen <input type="checkbox"/> 150mg PFS	<input type="checkbox"/> Maintenance: Inject 150mg SC every 12 weeks	1	
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	28-day supply	
		<input type="checkbox"/> (>220 lbs) Inject 90mg on day 0 then week 4, followed by 90mg dose every 12 weeks		
Taltz	<input type="checkbox"/> 80mg autoinjector pen	<input type="checkbox"/> Initial: Inject 160mg SC at week 0 then 80mg at weeks 2, 4, 6, 8, 10 and 12	28-day supply	
		<input type="checkbox"/> 80mg prefilled syringe	<input type="checkbox"/> Maintenance: Inject 80mg SC every 4 weeks	28-day supply
Tremfya	<input type="checkbox"/> 100mg prefilled pen	<input type="checkbox"/> Initial: Inject 100mg SC at week 0 and 4	2	0
		<input type="checkbox"/> 100mg prefilled syringe	<input type="checkbox"/> Maintenance: Inject 100mg SC every 8 weeks	1
Other				

Ship medications to: Physician's clinic Patient's home Injection training needed: Yes No

I authorize Vital Care Infusion Services LLC 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 that I order. Physician Signature: _____
 I understand that I can revoke this designation at any time by providing written notice to Vital Care. Date: _____

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

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

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.