Dermatology Referral Form

357 Flatbush Ave • Brooklyn, NY 11238
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SHIP TO:	❑ Patient's Home	❑ Provider's Office	❑ Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: ❑M ❑F	Primary Language:
Patient Address: (include apt. #)			City:	State:	Zip:
Primary Phone:	Alternate Phone:		Allergies:	Height: ❑in ❑cm Weight: ❑lbs ❑kgs	

PHARMACY INSURANCEINFORMATION: **Please include a copy of the front/back of pharmacy insurance card with this form**

Primary Insurance Name:	Insured's SSN:	Patient ID#:
Rx BIN#:	Rx PCN#:	Rx Group#:

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name:	Specialty:	Contact Name:	
Physician Address:	Phone #:	Secure Fax #:	
Physician DEA # :	Physician NPI #:	License #:	Tax ID #:

CLINICALINFORMATION:

Diagnosis/ICD-10:
- ❑ Psoriatic Arhtirits (L40.5)
- ❑ Plaque Psoriasis (L40.0)
- ❑ Chronic Idiopathic Urticaria (L50.1)
- ❑ Other: _____

Date of diagonsis: _____

Other Clinical Information:
- TB test performed? ❑ Yes ❑ No
  Date of negative test: _____
- HBV ruled out? ❑ Yes ❑ No
- If no, has treatment been initiated?
  ❑ Yes ❑ No
- Failed NSAIDs: _____

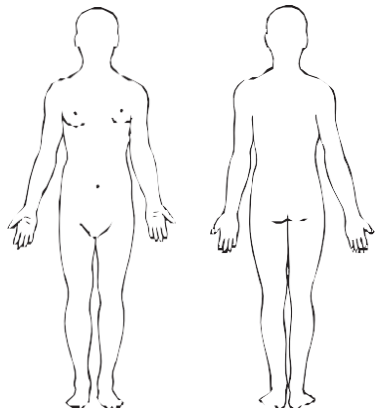
DMARDS:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
❑ Methotrexate	❑ (_____)	❑	_____
❑ Soriatane	❑ (_____)	❑	_____
❑ Cyclosporine	❑ (_____)	❑	_____
❑ _____	❑ (_____)	❑	_____

Topical Agents:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
❑ Clobetasol	❑ (_____)	❑	_____
❑ Hydrocortisone	❑ (_____)	❑	_____
❑ _____	❑ (_____)	❑	_____

Phototherapy:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
❑ UVA/UVB	❑ (_____)	❑	_____

❑ Patient cannot afford ❑ Photosensitivity ❑ Risk of skin cancer ❑ Distance from office

Specialty Drugs:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
❑ Humira	❑ (_____)	❑	_____
❑ Enbrel	❑ (_____)	❑	_____
❑ _____	❑ (_____)	❑	_____



Location:
❑ Hands ❑ Feet ❑ Scalp
❑ Groin ❑ Nails
❑ Other: _____

BSA (% is **required**): _____%

PRESCRIPTION INFORMATION: **Please include an original prescription or E scribe a prescription to Kings Pharmacy**

Medication	Dose/Strength	Directions	Quantity	Refills
❑ **ENBREL®**	❑ SureClick® Pen ❑ Pre-filled Syringe ❑ Vials	❑ Inject 50 mg SQ ONCE a week ❑ Inject 50 mg SQ TWICE a week 72-96 hours apart ❑ Inject 25 mg SQ TWICE a week 72-96 hours apart	❑ 4 ❑ 8	
❑ **HUMIRA®**	❑ Psoriasis Starter Kit ❑ Pen ❑ Pre-filled Syringe	❑ **Initial:** Inject 80 mg SQ on day 1, 40 mg on day 7, then 40 mg every OTHER week ❑ **Maintenance:** Inject 40 mg SQ every week ❑ **Maintenance:** Inject 40 mg SQ every OTHER week	❑ 2 ❑ 4	
❑ **OTEZLA®**	❑ Titration Starter Pack ❑ Bridge Dose Pack ❑ Tablets	❑ Take as directed **Only select for Titration Starter Pack** ❑ Take 30 mg PO ONCE daily ❑ Take 30 mg PO TWICE daily	❑ 27 tabs ❑ 28 tabs ❑ 30 tabs ❑ 60 tabs	
❑ **SIMPONI®**	❑ SmartJect® Pen ❑ Pre-filled Syringe	❑ Inject 50 mg SQ ONCE monthly	❑ 1 dose	
❑ **STELARA®**	❑ 45 mg/0.5 mL PFS ❑ 90 mg/mL PFS	❑ **Initial:** Inject contents of 1 PFS SQ on day 0 and day 28 ❑ **Maintenance:** Inject contents of 1 PFS SQ every 12 weeks	❑ 1 PFS	
❑ **Other**				

PRESCRIBER SIGNATURE: **DATE:**