Dermatology Referral Form

Please fax to
855.273.3925

2001 Campbell Station Pky STE A5
Spring Hill, TN 37174
p 855.273.3924

Patient Name:	Primary Ins:
DOB:	BinRx/PCN#:
SSN:	ID#:
Address:	Group#:
City/ST/Zip:	Phone#:
Phone#:	Secondary Ins:
Emergency contact#	Sex: M F
Diagnosis:	Height: Allergies:
ICD-10:	Weight:
TB/PPD: ____Positive ____Negative	% Body Surface Area Affected:

Previous treatment with: ____Topicals ____UV/UVB ____Corticosteroid ____Methotrexate ____5-ASA ____6-MP ____DMARD ___NSAIDS ____Azathioprine ____Remicade ____Other Biologics
Dates of Therapy:______________________________ Reason for Discontinuation:___________________________

HUMIRA		
❒ Psoriasis Starter Kit	❒ Inject 2 - 40mg (80mg) on Day 1, then 40mg on Day 8 and Day 22	_____QTY _____REFILLS
Hidradenitis Suppurativa ❒ 40mg PEN ❒ 40mg PFS	❒ **Initial Dose for Hidradenitis Suppurativa**: ❍Inject 4-40mg (160mg) on Day 1 **OR** ❍Inject 2-40 mg (80mg) on Day 1 and Day 2 and then Inject 2-40mg (80mg) on Day 15	_____QTY _____REFILLS
	❒ **Maintenance Dose for Hidradenitis Suppurativa**: Inject 1-40mg on Day 29 and every week thereafter	_____QTY _____REFILLS
❒ 40mg PEN ❒ 40mg PFS	❒ Inject 40mg subq every OTHER week ❒ Inject 40mg subq ONCE a week	_____QTY _____REFILLS
ENBREL		
❒ 25mg PFS ❒ 25mg vial ❒ 50mg PFS ❒ 50mg Sureclick	❒ **Initial Dose:** inject 50mg subq twice weekly for three months	__8__QTY __2__REFILLS
	❒ Inject 50mg subq once weekly ❒ ______________________________	_____QTY _____REFILLS
STELARA		
❒ 45mg PFS ❒ 45mg vial ❒ 90mg PFS ❒ 90mg vial	**Initial Dose** ❒ for patients <100kg, inject 45mg subq at weeks 0 and 4 ❒ for patients >100kg, inject 90mg subq at weeks 0 and 4	__2__QTY __0__REFILLS
	Maintenance Dose ❒ Inject ________mg every 12 weeks	_____QTY _____REFILLS
OTEZLA		
❒ Otezla	❒ Starter Pack	__1__QTY __0__REFILLS
	❒ 30mg tablet twice daily	_____QTY _____REFILLS
COSENTYX		
❒ 150mg PFS ❒ 150mg Sensoready PEN	**Initial Dose**: ❒ 150mg subq at Weeks 0, 1, 2, 3, and 4 ❒ 300mg subq at Weeks 0, 1, 2, 3, and 4	❒ __5__QTY __0__REFILLS ❒ __10__QTY __0__REFILLS
	Maintenance Dose: ❒ 150mg every 4 weeks ❒ 300mg every 4 weeks	_____QTY _____REFILLS
DUPIXENT		
❒ 300mg/2ml PFS	**Initial Dose**: ❒ 600mg subq (two 300mg injections in different injection sites), followed by 300mg subq given every other week	❒ __3__QTY __0__REFILLS
	Maintenance Dose: ❒ Inject 300mg subq every other week	❒ __2__QTY _____REFILLS

Deliver to: ___Patient's home ___MD's Office ___First dose to MD ___Pharmacy Training ___Physician Training in office

***By signing this form and utilizing our services, you are authorizing EntrustRx and our employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.**

Physician Signature DAW ____________ **Substitution Allowed** ____________ **Date** ____________

Physician Name:	Office Contact:	
Address:	Phone:	
Address:	Fax:	
City/St/Zip:	NPI:	DEA:

*** IMPORTANT NOTICE: This fax is intended to be delivered to the name addressee. It contains material confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify sender immediately.