



Specialty Pharmacy With A Personal Touch
wholly owned subsidiary of fred's inc.

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

<input type="checkbox"/> Psoriasis Starter Kit	<input type="checkbox"/> Inject 2 - 40mg (80mg) on Day 1, then 40mg on Day 8 and Day 22	___ QTY ___ REFILLS
Hidradenitis Suppurativa <input type="checkbox"/> 40mg PEN <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Initial Dose for Hidradenitis Suppurativa: <input type="radio"/> Inject 4-40mg (160mg) on Day 1 OR <input type="radio"/> Inject 2-40 mg (80mg) on Day 1 and Day 2 and then Inject 2-40mg (80mg) on Day 15	___ QTY ___ REFILLS
	<input type="checkbox"/> Maintenance Dose for Hidradenitis Suppurativa: Inject 1-40mg on Day 29 and every week thereafter	___ QTY ___ REFILLS
<input type="checkbox"/> 40mg PEN <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 40mg subq every OTHER week	___ QTY ___ REFILLS
	<input type="checkbox"/> Inject 40mg subq ONCE a week	

ENBREL

<input type="checkbox"/> 25mg PFS <input type="checkbox"/> 25mg vial <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 50mg Sureclick	<input type="checkbox"/> Initial Dose: inject 50mg subq twice weekly for three months	__ 8 __ QTY __ 2 __ REFILLS
	<input type="checkbox"/> Inject 50mg subq once weekly <input type="checkbox"/> _____	___ QTY ___ REFILLS

STELARA

<input type="checkbox"/> 45mg PFS <input type="checkbox"/> 45mg vial <input type="checkbox"/> 90mg PFS <input type="checkbox"/> 90mg vial	Initial Dose <input type="checkbox"/> for patients <100kg, inject 45mg subq at weeks 0 and 4 <input type="checkbox"/> for patients >100kg, inject 90mg subq at weeks 0 and 4	__ 2 __ QTY __ 0 __ REFILLS
	Maintenance Dose <input type="checkbox"/> Inject _____ mg every 12 weeks	___ QTY ___ REFILLS

OTEZLA

<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack	__ 1 __ QTY __ 0 __ REFILLS
	<input type="checkbox"/> 30mg tablet twice daily	___ QTY ___ REFILLS

COSENTYX

<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 150mg Sensoready PEN	Initial Dose: <input type="checkbox"/> 150mg subq at Weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> 300mg subq at Weeks 0, 1, 2, 3, and 4	<input type="checkbox"/> 5 QTY 0 REFILLS <input type="checkbox"/> 10 QTY 0 REFILLS
	Maintenance Dose: <input type="checkbox"/> 150mg every 4 weeks <input type="checkbox"/> 300mg every 4 weeks	___ QTY ___ REFILLS

DUPIXENT

<input type="checkbox"/> 300mg/2ml PFS	Initial Dose: <input type="checkbox"/> 600mg subq (two 300mg injections in different injection sites), followed by 300mg subq given every other week	<input type="checkbox"/> 4 QTY 0 REFILLS
	Maintenance Dose: <input type="checkbox"/> Inject 300mg subq every other week	<input type="checkbox"/> 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:	