



Specialty Pharmacy With A Personal Touch

Dermatology Referral Form

Please fax to:

866.279.3315

2402 Wilkins Wise Road, Ste 38

Columbus, MS 39705

p 866.279.3314

Patient Name:		Primary Ins:	
DOB:	SSN:	BinRx/PCN#:	
Address:		ID#:	Group#:
City/ST/Zip:		Phone#:	
Phone#:		Secondary Ins:	
Emergency contact#		Sex: M F	
Diagnosis: ICD-10:		Height: Weight: Allergies:	
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: ○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
	<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 <input type="checkbox"/> Inject 40mg subq ONCE a week	___ QTY ___ REFILLS

ENBREL

<input type="checkbox"/> 25mg PFS <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 25mg vial <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"/> 90mg PFS <input type="checkbox"/> 45mg vial <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"/> 150 mg PFS <input type="checkbox"/> 150 mg 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 300 mg subq given every other week	<input type="checkbox"/> ___ 2 ___ QTY ___ 0 ___ REFILLS
	Maintenance Dose: <input type="checkbox"/> Inject 300 mg subq every other week	<input type="checkbox"/> ___ 2 ___ QTY ___ 0 ___ REFILLS

TREMFYA

<input type="checkbox"/> Tremfya	Initial Dose: <input type="checkbox"/> 100mg subq at Week 0, and Week 4	___ 2 ___ QTY ___ 0 ___ REFILLS
	Maintenance Dose: <input type="checkbox"/> 100mg every 8 weeks	___ QTY ___ REFILLS

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

***By signing this form and utilizing our services, you are authorizing EntrustRx and it's 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:	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.