DERMATOLOGY REFERRAL FORM

Date: ___________________________

SUPERIOR BIOLOGICS
Fax Referral To:914-747-1170
Phone: 855-747-1150

Needs by Date: _________________ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: ___________________________________
Address: ___________________________________
City, State, Zip: ___________________________________
Home Phone: ___________________________________
Cell Phone: ___________________________________
Alternate Phone: ___________________________________
Date of Birth: ______________ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: ___________________________________
Address: ___________________________________
City, State, Zip: ___________________________________
Phone: ___________________________________
Fax: ___________________________________
DEA#: ___________________ NPI#: _________________
Contact Person: ___________________________________

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: ________________________________ ID#: __________________________ Group: ______________
Secondary Insurance: ________________________________ ID#: __________________________ Group: ______________
Prescription Card: _____________ ID#: ________________ BIN: ____________ PCN:__________ Group: ______________

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis ___________ **Date of Diagnosis** (or years with disease) ___________ **Allergies:** ________________________

Previously for the condition? ☐ Yes ☐ No If yes, medication/therapy failed (length) ______________________________________

Has patient received PPD (tuberculosis) Skin Test? ☐ Yes ☐ No **Does patient have a latex allergy?** ☐ Yes ☐ No

Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No **BSA** ____________ % affected by Psoriasis

Enbrel®

☐ 50mg/ml Prefilled Syringe
☐ 50mg/ml SureClick Autoinjector
☐ 25mg/0.5ml Prefilled Syringe

SIG: ☐ **Induction:** Inject 50mg SC twice a week (72-96 hrs apart for 3 months).
☐ **Maintenance:** Inject 50mg SC once a week.
☐ **Other** ____________________________

QTY: ___________ Refill: ___________

Cosentyx®

☐ 300mg ☐ 150mg
SIG: ☐ **Initial:** Inject SC weeks 0, 1, 2, 3, and 4
☐ **Maintenance:** Inject SC every 4 weeks
QTY: _________ Refill: _________

Otezla®

SIG: ☐ 28 day starter pack ☐ 30mg 2 x daily
QTY: _________ Refill: _________

Targretin® Capsules

☐ 75mg **SIG:** ____________________
QTY: __________ Refill: _________

Humira®

☐ 20mg/0.4ml Prefilled Syringe (2 doses)
☐ 40mg/0.8ml Pen (2 doses)
☐ 40mg/0.8ml Prefilled Syringe (2 doses)
☐ 40mg Kit 4 x 0.8ml
☐ 40mg Start Kit 6 x 0.3ml

SIG: ☐ **Initial Dose:** Inject 80mg SC on Day 1.
☐ **Maintenance:** Inject 40mg SC every other week (starting 1 week after initial)
☐ **Other** ________________________________

QTY: ☐ Initial Dose 1; Other: ____ Refill: ____

☐ Injection training required from My Humira

Sivextro®

☐ 200mg **SIG:** Take once daily for 6 days
QTY: __________ Refill: _________

Targretin® Gel

☐ 1% Gel **SIG:** Apply every other day for 1 week, then at weekly intervals: increase to once daily, twice daily, three times daily, and finally four times daily.
QTY: __________ Refill: _________

Stelara®

☐ 45mg/0.5ml Prefilled Syringe
☐ 90mg/1.0ml Prefilled Syringe

SIG: Starter Dose: ☐ Inject 45mg SC (patient < 100kg) at Day 1. ☐ Inject 90mg SC (patient < 100kg) at Day 1.

Maintenance Dose: ☐ Inject 45mg SC (patient < 100kg) 28 days after starter dose and then every 12 weeks. ☐ Inject 90mg SC (patient < 100kg) 28 days after starter dose and then every 12 weeks.

☐ **Other** ________________________

QTY: ☐ Initial Dose 1; Other: ___Refill: _____

Oxsoralen-Ultra®

☐ 10mg **SIG:** ____________________
QTY: __________ Refill: __________

Zolinza®

☐ 400mg **SIG:** ☐ 400mg once daily
☐ Other: ________________________
QTY: __________ Refill: __________

Zyvox®

☐ 600mg **SIG:** Twice daily for _____ days
QTY: __________ Refill: __________

Other/Notes:____
____

Prescriber Signature: ________________________________ **DAW (Dispense as Written) Date:** ____________

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