Dermatology Referral Form

Phone: (706) 849-4161 **Fax:** (706) 798-9683

PATIENT INFORMATION (Complete or include demographic sheet)	**PRESCRIBER INFORMATION**
Patient Name:_____ DOB:_____	Prescriber Name: _____
Address: _____	State License #: _____ NPI#: _____
City, State, Zip:_____	DEA#: _____
Primary Phone:_____	Organization:_____
Alternate Phone:_____ Gender:_____	Address:_____
Email:_____	City, State, Zip: _____
SSN:_____	Phone: _____ Fax: _____
Allergies:_____	Contact Person: _____ Tax ID: _____

INSURANCE INFORMATION: Please fax/scan the front and back of the insurance card

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, tests supporting information to expedite prior authorization process)

Diagnosis (ICD10) : _____ Date of Diagnosis: _____

Is Patient currently on therapy: □ Yes □ No If Yes, Medications: _____

Prior failed medications *(dates of therapy and reason for discontinuation*): _____

_____

Has Negative Tb test/PPD: ☐ Yes ☐ No Tb Test Date:_____ Has Hepatitis B been ruled out or treatment been initiated: □ Yes □ No

Does patient have a latex allergy? : ☐ Yes ☐ No

Indicate areas of body affected: _____ % of body affected: _____

□ Attached active medication list for pharmacist review

Delivery Options: ☐ Patient home ☐ Office ☐ Other (specify): _____

Injection Training: Expected date: _____ ☐ MD office ☐ Barney's Specialty ☐ Alternate program

MEDICATION	DOSE/STRENGTH	SIG	QTY	REF
□ **Cosentyx**	□ 150mg/ml Sensoready Pen □ 150mg/ml Prefilled Syringe	□ Induction Dose: Inject 300mg weekly for 5 weeks □ Maintenance Dose: Inject 300mg once every 4 weeks	□ 10 □ 2	
□ **Enbrel**	□ 50mg/ml Prefilled Syringe □ 50mg/ml SureClick Autoinjector □25mg/0.5ml Prefilled Syringe	□ Induction Dose: Inject 50mg SC TWICE a week (72-96 hours apart for three months) □ Maintenance Therapy: Inject 50mg SC once week	□ 8 □ 4	
□ **Humira**	□ 20mg/0.4ml Prefilled Syringe □ 40mg/0.8ml Pen □ 40mg/0.8ml Prefilled Syringe □ 40mg Kit (4x0.8ml) □ 40mg Starter Kit (6x0.8ml)	□ Initial Dose: Inject 80mg SC on day 1 and day 15 □ Maintenance Dose: Inject 40mg SC every other week (starting 1 week after initial dose)	□ 4 □ 2	
□ **Otezla**	□ 30mg	□ Take one tablet twice daily	□ 60	
□ **Soriatane**	□ 10mg □ 17.5mg □ 25mg	□ Take one capsule daily. Take with food.	□ 30	
□ **Stelara**	□ 45mg/0.5ml Syringe □ 90mg/ml Syringe	□ Inject one syringe every 3 months	□ 1	
□ **Zolinza**	□ 100mg	□ Take four capsules (400mg) daily. Take with food.	□120	
□ **Other**				

Patient Support Program: Please sign and date below to enroll in the pharmaceutical company assisted patient support programs and patient funding.

PATIENT SIGNATURE _____ Date: _____

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

X_____ X_____

Dispense as written/Date Substitution Permitted/ Date