RX BIOTECH

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SPECIALTY PHARMACY

DERMATOLOGY REFERRAL FORM

Phone: **800-657-2212**
Fax: **310-657-0906**

Please FAX TO: **310-657-0906**
Toll Free Ph: **800-657-2212**

Date Shipment needed_____
Ship To: ☐ Patient ☐ Physician

PATIENT

Patient Name:_____
Address: _____
City:_____ State:_____ Zip:_____
Home Phone :(___) _____
Work Phone: (___) _____
Cell Phone: (___) _____
Patient Soc. Sec #:_____ Language :_____
Date of Birth:_____
See attached demographic sheet

PHYSICIAN

Physician Name:_____
State Lic. #:_____DEA#_____
NPI: _____Tax ID#_____
Address:_____
City:_____State:_____ZIP:_____
Physician's Ph: (____)_____-_____
Physician's Fax: (____)_____-_____
Nurse/Key Office Contact:_____
Specialty:_____

INSURANCE INFORMATION
(Attach Copies of Cards and FAX along this form)

CLINICAL INFORMATION

Diagnosis: _____ ICD-9 Codes:_____ Allergies: _____

Please list failed meds relevant to the diagnosis:

Med	dose	duration	reason to D/C
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Home Health Nurse Required: ☐ No ☐ Yes

Please indicate all relevant lab results:
TB Test date and result: _____
Other clinical findings: _____
_____
_____
_____
_____
Evaluated for Hep-B Yes ☐ No ☐

TREATMENT :

☐ **Humira** 40mg (Pen)
Initial dose: Starter Pack ☐ Inject two 40mg pens SC for first dose (day1)
Inject one 40 mg pen SC one week after first dose (day8)
Inject one 40 mg pen SC three weeks after first dose (day 22)
(Starter Pack)
Maintenance Dose: ☐ Inject one 40mg pen SC every other week Refills _____

☐ **Enbrel** 50 mg/ml PFS (Pre-filled Syringes)

Initial dose:
☐ 50 mg SQ BIW (72-96 Hours)
For 3 months, please specify number of refills (Maximum of 2 refills)
Maintenance Dose: ☐ 50 mg SQ QWK Refills _____

☐ **Stelara** 45mg/0.5ml ☐ 45 mgSQ at wks 0, 4 and q 12 weeks (from wk 4) Refills _____
☐ 90 mgSQ at wks 0, 4 and q 12 weeks (from wk 4)

Physician's Signature : _____Date:_____

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