InfuCare Rx

Dermatology Referral Form

of Pages Faxed:_____
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required:_____ Ship To: ☐ Patient ☐ MD Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Date of Birth:_____ ☐ Male ☐ Female
Emergency Contact:_____ Phone:_____

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:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ L20.89 Atopic Dermatitis
☐ L73.2 Hidradenitis
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ Other:_____
Prior Medication Failed:_____
Length of Treatment:_____
Reason for Discontinuation:_____

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read:_____
Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other:_____
Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in %BSA:_____
Allergies:_____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other:_____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	
☐ Cosentyx®	☐ 300mg (2x150) Pen ☐ PFS ☐ 150mg Pen ☐ PFS	☐ Load: Inject ☐ 300mg or ☐ 150mg SC week 0,1,2,3,4 ☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SC every 4 weeks	5 week supply 4 week supply	
☐ Dupixent®	☐ 300mg/2ml PFS	☐ Inject 600mg (two 300mg injections in different injection sites) SC on day 0, then 300mg day 14 and day 28 ☐ Inject 300mg SC every other week	1 month supply	
☐ Enbrel®	☐ 50mg Sureclick ☐ 25mg Vials ☐ 50mg PFS ☐ 25mg PFS	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg twice weekly	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SC once a week ☐ Inject 40mg SC every other week ☐ Inject 80mg day 1, then 40mg day 8, then 40mg every other week ☐ Inject 160mg day 1, then day 15 inject 80mg, then starting day 29 inject 40mg every week	1 month supply	
☐ Otezla®	☐ 30mg tablet ☐ Starter Pack	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily ☐ Starter Pack: Take 1 tablet by mouth day 1, then take 1 tablet by mouth twice daily as directed	1 month supply	
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SC once monthly	1 month supply	
☐ Stelara®	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45mg day 1 and week 4, then every 12 weeks ☐ Inject 45mg every 12 weeks ☐ Inject 90mg day 1 and week 4, then every 12 weeks ☐ Inject 90mg every 12 weeks	1 month supply	
☐ Tremfya™	☐ 100mg PFS	☐ Inject 100mg SC on week 0 and week 4 ☐ Inject 100mg SC every 8 weeks	1 month supply	
☐ Other:				

By signing this form and using our services, you are authorizing InfuCare Rx to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature:_____ **Date:**_____