

## Dermatology Referral Form

*Please attach copy of insurance cards (front and back)*

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City:	State:	Zip:	
Phone:	SSN:	Prescriber Name:	

### Insurance Information

Insurance Plan:	Insurance Plan:	Prescriber NPI:
Policy #	Policy #	Nurse/Key Contact:
Plan I.D. #	Plan I.D. #	Phone: Fax:
		Email:

### Clinical Information – Statement of Medical Necessity

*Please attach clinical/progress notes and test results supporting primary diagnosis*

Diagnosis:  L40.8 Moderate to severe plaque psoriasis     L40.50 Psoriatic arthritis     L73.2 Hidradenitis suppurativa  
 L20.9 Atopic dermatitis     Other \_\_\_\_\_

Severity of condition:  Mild (up to 3% BSA)     Moderate (3-10% BSA)     Severe (>10% BSA) BSA% \_\_\_\_\_

Location:  Hands     Feet     Scalp     Groin     Nails     Other \_\_\_\_\_

Prior failed meds:  Methotrexate    Length of treatment \_\_\_\_\_    Reason for discontinuing \_\_\_\_\_  
 PUVA/UVB    Length of treatment \_\_\_\_\_    Reason for discontinuing \_\_\_\_\_  
 Topicals    Length of treatment \_\_\_\_\_    Specific meds \_\_\_\_\_  
 Other    Length of treatment \_\_\_\_\_    Specific meds \_\_\_\_\_

TB/PPD test given?  Yes  No     Positive  Negative    Date \_\_\_\_\_    Allergies \_\_\_\_\_

Treatment location:  Home     Infusion suite     Other \_\_\_\_\_

### Labs

Test	Frequency

### Nursing Orders

- Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

### Prescription Information

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Infliximab	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 75mg 2 PFS kit	<input type="checkbox"/> Initial: Inject 150mg subcutaneously on week 0 and 4	1	0
	<input type="checkbox"/> 150mg pen <input type="checkbox"/> 150mg PFS	<input type="checkbox"/> Maintenance: Inject 150mg subcutaneously every 12 weeks	1	
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg vial	<input type="checkbox"/> (<220 lbs) Inject 45mg on day 0 then week 4, followed by 45mg dose every 12 weeks	28-day supply	
		<input type="checkbox"/> (>220 lbs) Inject 90mg on day 0 then week 4, followed by 90mg dose every 12 weeks		
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg prefilled pen	<input type="checkbox"/> Initial: Inject 100mg subcutaneously at week 0 and 4	2	0
	<input type="checkbox"/> 100mg prefilled syringe	<input type="checkbox"/> Maintenance: Inject 100mg subcutaneously every 8 weeks	1	
<input type="checkbox"/> Other				

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED**

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This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations. This is not a valid prescription in the state of Arizona.