vitalcare of SOUTH DALLAS

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Dermatology Referral Form

Please attach copy of insurance cards (front and back)

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip: Sex: ☐ M ☐ F	City: State: Zip:
Phone:	SSN:		Prescriber Name:
Insurance Information			Prescriber NPI:
Insurance Plan:	Insurance Plan:		Nurse/Key Contact:
Policy #	Policy #		Phone: Fax:
Plan I.D. #	Plan I.D. #		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
☐ Infliximab	☐ 100mg vial	☐ Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks		
☐ Skyrizi	☐ 75mg 2 PFS kit ☐ 150mg pen ☐ 150mg PFS	☐ Initial: Inject 150mg subcutaneously on week 0 and 4	1	0
		☐ Maintenance: Inject 150mg subcutaneously every 12 weeks	1	
☐ Stelara	☐ 45mg vial	☐ (<220 lbs) Inject 45mg on day 0 then week 4, followed by 45mg dose every 12 weeks ☐ (>220 lbs) Inject 90mg on day 0 then week 4, followed by 90mg dose every 12 weeks	28-day supply	
☐ Tremfya	☐ 100mg prefilled pen ☐ 100mg prefilled syringe	☐ Initial: Inject 100mg subcutaneously at week 0 and 4	2	0
		☐ Maintenance: Inject 100mg subcutaneously every 8 weeks	1	
☐ 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