

# Dermatology Therapies

Please fax completed referral form to 281-295-4088

## PATIENT DEMOGRAPHIC INFORMATION

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

### Diagnosis: (ICD 10 Code Required)

Plaque Psoriasis (L40.0-L40.9), ICD 10 \_\_\_\_\_  Arthropathic Psoriasis (L40.50-L40.59), ICD 10 \_\_\_\_\_  
 Idiopathic Urticaria, L50.1  Other Urticaria, L50.8  Other: \_\_\_\_\_

### Prior Failed Therapy:

Med Failed: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
Med Failed: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
Med Failed: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

### Test Results: Please attach copy for all items checked.

Negative TB test  
 Other: \_\_\_\_\_

Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.

## THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
Xolair® (omalizumab)	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg	<input type="checkbox"/> Inject SUBQ every 4 weeks x 1 year
Remicade® (infliximab)	<input type="checkbox"/> 5mg/kg: _____mg <input type="checkbox"/> Other: _____mg	<input type="checkbox"/> INITIAL: Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> MAINTENANCE: Infuse IV every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Infuse IV every ____ weeks x 1 year
Renflexis® (infliximab-abda)	<input type="checkbox"/> 5mg/kg: _____mg <input type="checkbox"/> Other: _____mg	<input type="checkbox"/> INITIAL: Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> MAINTENANCE: Infuse IV every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Infuse IV every ____ weeks x 1 year
Inflectra® (infliximab-dyyb)	<input type="checkbox"/> 5mg/kg: _____mg <input type="checkbox"/> Other: _____mg	<input type="checkbox"/> INITIAL: Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> MAINTENANCE: Infuse IV every 8 weeks x 1 year <input type="checkbox"/> MAINTENANCE: Infuse IV every ____ weeks x 1 year
Simponi Aria® (golimumab)	_____mg (2mg/kg)	<input type="checkbox"/> LOADING: Infuse IV at Weeks 0 and 4 <input type="checkbox"/> MAINTENANCE: Infuse IV every 8 weeks x 1 year
Ilumya® (tildrakizumab-asmn)	100mg	<input type="checkbox"/> INITIAL: Inject SUBQ at Weeks 0 and 4 <input type="checkbox"/> MAINTENANCE: Inject SUBQ every 12 weeks x 1 year
Dupixent® (dupilumab)	INITIAL: 600mg MAINTENANCE: 300mg	<input type="checkbox"/> INITIAL: Inject 600mg SUBQ x 1 dose <input type="checkbox"/> MAINTENANCE: Inject 300mg SUBQ every 2 weeks x 1 year
OTHER: _____		

Is patient currently receiving therapy above from another facility?  NO  YES If yes, Facility Name: \_\_\_\_\_

## REFERRING PHYSICIAN INFORMATION

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_



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