EL NORTE
Retail & Specialty Pharmacy

DERMATOLOGY REFERRAL FORM

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ■ Pick Up ❑ Date Needed: _____ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION					PRESCRIBER INFORMATION	
	Patient Name				**Prescriber Name**	
	Address				**NPI**	
	City, State, Zip				**Address**	
	Primary Phone		**Alt. Phone**		**City, State, Zip**	
	Date of Birth		**Allergies**		**Office Phone:**	
	Height/ Weight		**Sex:**	❑ Male ❑ Female	**Office Fax:**	
	Insurance	**PLEASE FAX A COPY OF INSURANCE CARD(S)**			**Contact Person**	

CLINICAL INFORMATION

Diagnosis: ❑ Psoriasis ❑ Psoriatic Arthritis ❑ Eczema ❑ Atopic Dermatitis ICD10 Code: _____ ❑ Other: _____ **Disease Severity**: ❑ Mild ❑ Moderate ❑ Severe

PPD/Chest X-Ray for TB ❑ Yes ❑ No Date of Negative TB test: _____ **% BSA Affected by Psoriasis**: ❑ > 5% ❑ < 5% ❑ Other: _____

Hepatitis B Test: ❑ **Positive** ❑ Negative **Does patient have CHF** ❑ Yes ❑ No **Does patient have active infection/malignancy?** ❑ Yes ❑ No

Tried/Failed Previous Therapies: DMARDS ❑ Yes ❑ No Please List: _____ If no, please explain why: _____
Biologics: ❑ Yes ❑ No Please List: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **CIMZIA**	❑ Cimzia Starter Kit (6 prefilled syringes)	❑ Induction Dose: Inject 400 mg SC on day 1, and week 2, and at week 4		
	❑ 200 mg/1mL PFS ❑ 200 mg vial	❑ Maintenance Dose: Inject 200 mg SC every other week ❑ Maintenance Dose: Inject 400 mg SC every 4 weeks ❑ Other: _____		
❑ **COSENTYX**	❑ 150 mg/mL PFS ❑ 150 mg/mL PEN	❑ Induction Dose: Inject 300 mg (2 injections of 150mg) SQ at week 0, 1, 2, 3, and 4 then 300mg SQ every 4 weeks ❑ Maintenance Dose: Inject 300mg SQ every 4 weeks		
❑ **ENBREL**	❑ 25 mg vial ❑ 25 mg/0.5mL PFS ❑ 50 mg/mL Sureclick ❑ 50 mg/mL PFS	❑ Inject 25 mg SC twice weekly (72 to 96 hrs apart) ❑ Inject 50 mg SC once weekly ❑ Other: _____		
❑ **HUMIRA**	❑ 40 mg/0.8ml Starter Kit ❑ 40 mg/0.8mL PFS ❑ 40 mg/0.8mL PEN	❑ Inject 80 mg SQ day 0, then 40mg day 7, then 40mg every other week ❑ Inject 40 mg SC every other week ❑ Other:_____		
❑ **OTEZLA**	❑ Titration Starter Pack	❑ Day 1: Take 10mg po QAM Day 2: Take 10mg po BID Day 3: Take 10mg po QAM and 20mg po QPM Day 4: Take 20mg po BID Day 5: Take 20mg po QAM and 30mg po QPM then take 30mg BID thereafter		
	❑ 30 mg tablets	❑ Take 30 mg by mouth twice daily		
❑ **SILIQ**	❑ 210 mg/1.5mL PFS	❑ Inject 210 mg SQ at weeks 0, 1, then every 2 weeks thereafter (Prescriber must be certified to prescribe SILIQ)		
❑ **SIMPONI**	❑ 50 mg/0.5mL SmartJect ❑ 50 mg/0.5mL PFF	❑ Inject 50 mg SC once every month		
❑ **STELARA**	❑ 45 mg/0.5mL PFS ❑ 90 mg/mL PFS	❑ For patients weighing ≤ 100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks ❑ For patients weighing > 100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks.		
❑ **TALTZ**	❑ 80mg	❑ Inject 160 mg (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks ❑ Inject 160 mg SC at Week 0, then 80 mg every 4 weeks		
❑ **TREMFYA**	❑ 100 mg/mL PFS	❑ Inject 100 mg SQ at week 0, 4, and every 8 weeks thereafter		
❑ **DUPIXENT**	❑ 300 mg/2mL PFS	❑ Initial dose 600mg (2 syringes) SC week 0, followed by 300mg (1 syringe) SC every 2 weeks		
❑ **EUCRISA**	❑ 2% ointment	❑ Apply a thin layer of Eucrisa to the affected area(s) twice daily		
❑ **OTHER**				

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ Date: _____