Dermatology Therapies

Please fax completed referral form to 972-473-7563

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)	☐ 150mg ☐ 300mg	☐ Inject SUBQ every 4 weeks x 1 year
Remicade® (infliximab)	☐ **5mg/kg:** ________mg ☐ **Other:** ________mg	☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year
Simponi Aria™ (golimumab)	_______mg (2mg/kg)	☐ **LOADING:** Infuse IV at Weeks 0 and 4 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year
OTHER:		
OTHER:		
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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