Advanced Pharmacy & Respiratory Care Solutions

"Personalized Specialty Healthcare"
26611 Cabot Rd.
Laguna Hills, CA 92653

Dermatology Referral

Patient Information	Physician Information
Patient Name:	Physician Name:
DOB: Sex: ☐ M ☐ F	Lic# NPI:
Address:	Address:
City/State/Zip	City/state/zip:
Phone:	Phone Fax:
Alt Phone:	Office Contact : ext:

Insurance Information:	
Primary Insurance:	Secondary Insurance:
Subscriber:	Subscriber:
ID#:	ID#:
Group Policy:	Group Policy:
Phone:	Phone:
Employer:	Employer:

Prescription:	DOSE/Directions:
Stelara® (ustekinumab)	☐45 mg/0.5 mL in a single-use pre-filled syringe ☐ 90 mg/1 mL in a single-use pre-filled syringe ☐45 mg/0.5 mL in a single-use vial ☐90 mg/1 mL in a single-use vial Sig: _____ _____refill
Enbrel® (etanercept)	☐Enbrel 50-mg/mL SureClick ☐ Enbrel 50-mg/mL prefilled syringe ☐ Enbrel 25-mg multiuse vial ☐ Enbrel 25-mg/0.5-mL prefilled syringe Sig: _____mg Q _____days _____refills
Amevive® (alefacept)	☐15mg vial
Humira® (adalimumab)	☐40 mg/0.8 mL in a single-use prefilled pen (Humira Pen) ☐40 mg/0.8 mL in a single-use prefilled glass syringe ☐20 mg/0.4 mL in a single-use prefilled glass syringe Sig: _____ Q ____weeks ____refills
Remicade® (infliximab)	☐ Introduction dose _____mg/kg _____mg IV Q _____weeks ☐ Maintainance Dose _____mg/kg ____mg IV Q ___ weeks
Simponi™ (golimumab)	SIG: _____mg/_____mL Q _____weeks ☐ Smartject ☐ Prefilled Syringe
(write in additional RX)	

Diagnosis/Statement of Medical Necessity: (please include all relevant documentation when faxing)

Signature: _____ Date: _____

Fax to 949-582-6111