



DERMATOLOGY REFERRAL FORM

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- Phone Order
Ship to Patient:
Home Work
Ship to:
Physician Office
Nurse / Training
APS Pharmacy

Patient Name, Address, Telephone, Allergies, Current Medications, Primary Insurance, Insured's Name, City, State, Phone, ID#, Group #, Employer

ICD-10 Diagnosis Code, PPD (TB Test), % BSA (body surface area) affected by Psoriasis, Methotrexate contraindicated, Previously treated for this condition?

Table with columns: Medication, Strength, Duration of Treatment/Reason for Discontinuation, Oral Meds, Phototherapy

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

DUPIXENT, ILUMYA, SILIQ, TREMFYA, COSENTYX, HUMIRA and HUMIRA Citrate-Free, OTHER

OTEZLA, TALTZ, SIMPONI, RASUVO, ENBREL, STELARA, REMICADE

Prescriber's Name / Practice, Address, Tel, Fax, License#, NPI#, UPIN#, DEAN#, Office Contact, City, State, Zip, Date