

Dermatology Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:

p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

This form is not a valid prescription

-----<----- Please detach before submitting to a pharmacy. Cut or tear here. ----->-----

PATIENT INFORMATION					
Patient Name			DOB	Contact Phone	
Address		City	State	Zip	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)	Height (in.)	
<input type="checkbox"/> NKDA	<input type="checkbox"/> Allergies			Date	
ICD-10 code (required)			ICD-10 description		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy		TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Screen <input type="checkbox"/> Yes <input type="checkbox"/> No		
PRESCRIBER INFORMATION					
Ordering Prescriber			Prescriber NPI		
Practice Name			Phone	Fax	
Practice Address		City	State	Zip	
REQUIRED DOCUMENTATION					
<input type="checkbox"/> Insurance Cards		<input type="checkbox"/> History & Physical		<input type="checkbox"/> Medication List	
<input type="checkbox"/> Most Recent Labs					
DERMATOLOGY TREATMENT PLAN					
<input type="checkbox"/> Remicade® or Biosimilar _____ Loading dose: <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter			<input type="checkbox"/> Stelara® or Biosimilar _____ <input type="checkbox"/> 45mg subcutaneously at initial, and week 4. Followed by 45mg subcutaneously every 12 weeks after (patients < 100kg) <input type="checkbox"/> 90mg subcutaneously at initial, and week 4. Followed by 90mg subcutaneously every 12 weeks after (patients > 100kg)		
<input type="checkbox"/> Rituxan® <input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg Administer IV at day 1, then at day 15. Administer every _____ months thereafter			<input type="checkbox"/> Skyrizi® <input type="checkbox"/> Loading Doses - Inject 150 mg SC at weeks 0 and 4 <input type="checkbox"/> Maintenance Dose - Inject 150 mg SC every 12 weeks thereafter		
<input type="checkbox"/> Simponi Aria® <input type="checkbox"/> 2mg/kg IV infusion over 30 min, then at week 4 and then every 8 weeks thereafter			<input type="checkbox"/> Tremfya® <input type="checkbox"/> Loading Doses - Inject 100 mg SC weeks 0 and 4 <input type="checkbox"/> Maintenance Dose - Inject 100 mg SC every 8 weeks thereafter		
<input type="checkbox"/> Other		Include dosage, frequency and any other special instructions.			
<input type="checkbox"/> Refill for 1 year					
NURSING					
Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.					
PREMEDICATION			LABORATORY ORDERS		
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.			<input type="checkbox"/> CBC every _____		
<input type="checkbox"/> Other _____			<input type="checkbox"/> CMP every _____		
			<input type="checkbox"/> Other		

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.