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 ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐NKDA	☐Allergies		Date
ICD-10 code (required)		ICD-10 description	
Patient Status ☐New to Therapy ☐Continuing Therapy		TB Skin Test ☐Yes ☐No	Hepatitis B Screen ☐Yes ☐No

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐Insurance Cards	☐History & Physical	☐Most Recent Labs	☐Medication List

DERMATOLOGY TREATMENT PLAN

☐ Remicade® or Biosimilar _____
Loading dose: ☐5mg/kg ☐7.5mg/kg ☐10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter

☐ Stelara® or Biosimilar _____
- ☐ 45mg subcutaneously at initial, and week 4. Followed by 45mg subcutaneously every 12 weeks after (patients < 100kg)
- ☐ 90mg subcutaneously at initial, and week 4. Followed by 90mg subcutaneously every 12 weeks after (patients > 100kg)

☐ Rituxan®
☐500mg ☐1000mg
Administer IV at day 1, then at day 15. Administer every _____ months thereafter

☐ Skyrizi®
- ☐ Loading Doses - Inject 150 mg SC at weeks 0 and 4
- ☐ Maintenance Dose - Inject 150 mg SC every 12 weeks thereafter

☐ Simponi Aria® ☐ 2mg/kg IV infusion over 30 min, then at week 4 and then every 8 weeks thereafter

☐ Tremfya®
- ☐ Loading Doses - Inject 100 mg SC weeks 0 and 4
- ☐ Maintenance Dose - Inject 100 mg SC every 8 weeks thereafter

☐ Other — Include dosage, frequency and any other special instructions.

☐ 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

☐ Include premedication per Pharmacy's infusion protocol.

☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ 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).