DERMATOLOGY REFERRAL FORM

Date: _____

Y Medical Associates
Fax: 855-838-0623
Phone: 800-447-7558

YMedical ASSOCIATES

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____
Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

Clinical Information (please fax all pertinent clinical information)

Diagnosis: ☐ L20.9 (Atopic Dermatitis) ☐ L40.0 (Psoriasis Vulgaris/Plaque Psoriasis/Nummular Psoriasis) ☐ L40.8 (Other Psoriasis)
☐ L40.9 (Psoriasis/Unspecified) ☐ L40.5 (Psoriatic Arthritis) ☐ L73.2 (Hidradenitis Suppurativa)
☐ M33 (Dermatopolymyositis) ☐ M33.1 (Dermatomyositis) ☐ L12.9 (Pemphigoid/Pemphigus) ☐ L10.0 (Pemphigus Vulgaris)
Diagnosis Date: _____ Height: _____ Weight: _____ Tb Test: ☐ Yes ☐ No Neg. Text Date: _____
HBV: ☐ Yes ☐ No If Yes, Currently Treated: ☐ Yes ☐ No Allergies: _____
BSA Affected (%): _____ Affected Areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ _____
Prior Therapy: ☐ Yes ☐ No Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____ Approximate End Date: _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Cimzia	☐ 6 x 200mg/mL (PFS Starter Kit) ☐ 2 x 200mg/mL PFS ☐ 2 x 200mg/mL Vial	☐ Inject 400mg SC at weeks 0, 2 and 4 ☐ Inject 200mg SC every 2 weeks ☐ Inject 400mg SC every 4 weeks ☐ For some patients <90kg: Inject 400mg SC at weeks 0, 2 and 4, then 200mg every 2 weeks		
Cosentyx	☐ 300mg Sensoready Pen ☐ 150mg Sensoready Pen	☐ **Starter Dose:** Inject SC weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject SC every 4 weeks		
Dupixent	☐ 300mg PFS ☐ 200mg PFS	☐ **Starter Dose:** Inject 400 mg (two 200 mg injections) ☐ **Starter Dose:** Inject 600 mg (two 300 mg injections) ☐ **Maintenance Dose:** Inject 200mg SC every 2 weeks thereafter ☐ **Maintenance Dose:** Inject 300mg SC every 2 weeks thereafter		
Enbrel	☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL SureClick Autoinjector ☐ 25mg/0.5mL Prefilled Syringe	☐ **Starter Dose:** Inject 50mg SC twice a week (72-96 hours apart for 3 months) ☐ **Maintenance Dose:** Inject SC every 4 weeks		
☐ Humira ☐ Adalimumab *(biosimilar)*	☐ 20mg/0.2mL Pen ☐ 40mg/0.4mL Pen ☐ 40mg/0.8mL Pen or Syringe ☐ 40mg Kit 4 x 0.8mL ☐ 40mg Psoriasis Starter Pack	☐ **Starter Dose:** Inject 80mg SC on Day 1 ☐ **Maintenance Dose:** Inject 40mg SC once weekly thereafter Other: _____	☐ Initial Dose 1: Other: _____ ☐ Injection training required from my Humira	
Ilumya	☐ 100mg/mL Prefilled Syringe	☐ **Starter Dose:** Inject 100mg SC at weeks 0 and 4 ☐ **Maintenance Dose:** 100mg SC every 12 weeks		

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Diagnosis Date: _____ Height:_____ Weight:_____Tb Test: ☐ Yes ☐ No Neg. Text Date: _____

HBV: ☐ Yes ☐ No If Yes, Currently Treated: ☐ Yes ☐ No Allergies: _____

BSA Affected (%): _____ Affected Areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ _____

Prior Therapy: ☐ Yes ☐ No Reason for Discontinuation of Therapy: _____

Approximate Start Date: _____ Approximate End Date: _____

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Medication	Dose Strength	Directions	Qty	Refills
IVIG Orders		_____mg/kg IV divided over _____ day(s) _____mg/kg IV divided over _____ day(s) **Frequency:** ☐ Every _____ weeks for one year ☐ one time dose		
Orencia	☐ 150mg PFS ☐ 250mg/mL Vial ☐ 125mg ClickJect Pen	☐ **Starter Dose:** Infuse _____ mg at weeks 0, 2, and 4 ☐ **Maintenance Dose:** Infuse _____ mg at every 4 weeks thereafter (<60kg = 500mg, 60kg to 100kg = 750mg, and >100kg = 1000mg) ☐ **SC**: Inject 125mg SC once a week		
Otezla	☐ 28 Day Starter Pack ☐ 30mg	☐ **Starter Pack:** Take as Directed ☐ **Maintenance Dose:** Take 1 Table BID		
☐ Remicade ☐ Avsola ☐ Inflectra ☐ Renflexis	☐ 100mg Vial	☐ **Starter Dose:** 5mg/kg (dose _____ mg) IV at 0, 2, and 6 weeks, then every 8 weeks thereafter ☐ **Maintenance Dose:** 5mg/kg (dose _____ mg) IV every 8 weeks IV_____ mg every _____ weeks		
Rituxan	☐ 100mg Vial	☐ **Loading Dose:** 1000mg IV at Day 0 and Day 15 ☐ **Maintenance Dose:** 50mg IV at month 12 and every 6 months thereafter		
Siliq	☐ 210mg/1.5mL PFS	☐ **Loading Dose:** Inject 210mg SC at weeks 0,1, and 4 ☐ **Maintenance Dose:** 210mg SC every 2 weeks thereafter	☐ Starter Dose: 3 PFS ☐ Maintenance Dose 2 PFS	

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BSA Affected (%): _____ Affected Areas: ☐ Palms ☐ Soles ☐ Head ☐ Neck ☐ Genitalia ☐ _____
Prior Therapy: ☐ Yes ☐ No Reason for Discontinuation of Therapy: _____
Approximate Start Date: _____ Approximate End Date: _____

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Simponi / Simponi Aria	☐ 100mg/mL Autoinjector ☐ 100mg/mL PFS ☐ 50mg/mL Autoinjector ☐ 50mg/mL PFS ☐ 50mg/4mL Vial	☐ Inject 100mg SC once a month ☐ Inject 50mg SC once a month ☐ Infuse _____ mg (2mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks)	☐ 4 week supply	
Skyrizi	☐ 75mg/0.83mL (150mg dose)	☐ **Initial Dose:** Inject 150mg SC weeks 0, and 4 ☐ **Maintenance Dose:** Inject 150mg SC every 12 weeks		
Stelara	☐ 45mg/0.5mL PFS ☐ 90mg/1.0mL PFS	**Starter Dose:** ☐ Inject 45mg SC (pt<100kg) on Day 1 and Day 28 ☐ Inject 90mg SC (pt>100kg) on Day 1 and Day 28 **Maintenance Dose:** ☐ Inject 45mg SC (pt<100kg) every 12 weeks thereafter ☐ Inject 90mg SC (pt>100kg) every 12 weeks thereafter	☐ Initial Dose: 1 other: _____	
Taltz	☐ 80mg/mL Autoinjector	☐ **Starter Dose:** Inject 160mg SC at week 0, then 80mg at weeks 2, 4, 6, 8, 10, and 12 weeks ☐ **Maintenance Dose:** Inject 80mg SC every 4 weeks		
Tremfya	☐ 100mg PFS	☐ Inject 100mg SC on weeks 0 and 4 ☐ Inject 100mg SC every 8 weeks	☐ 1 Plus Refill ☐ 1	
Xeljanz/XR		☐ Take 5mg PO BID ☐ Take 11mg PO once daily		

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