

Dermatology Referral Form



Phone: 808-533-8887
 Fax: 808-533-1888
 E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: Patient Physician

Patient	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> NKDA

Provider	Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
	Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
	Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance	Primary Insurance: _____ ID: _____ Phone: _____
	Secondary Insurance: _____ ID: _____ Phone: _____
	* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info	Diagnosis: <input type="checkbox"/> L40.59 Psoriatic Arthritis <input type="checkbox"/> L40.8 Psoriasis <input type="checkbox"/> Other ICD 10 _____
	Location: <input type="checkbox"/> Scalp <input type="checkbox"/> Groin <input type="checkbox"/> Nails <input type="checkbox"/> Others _____
	Severity: <input type="checkbox"/> Mild (<3%BSA) <input type="checkbox"/> Moderate (3-10% BSA) <input type="checkbox"/> Severe (>10% BSA)
	PPD Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____
Current/ Failed Therapies: _____	

Prescription

Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Enbrel [®] (Etanercept) 50 mg PFS <input type="checkbox"/> Enbrel [®] (Etanercept) 50 mg SureClick Autoinjector	<input type="checkbox"/> 50 mg SQ twice weekly for 3 months, then weekly <input type="checkbox"/> 50 mg SQ once weekly <input type="checkbox"/> 25 mg SQ twice weekly <input type="checkbox"/> _____		____ kits	
<input type="checkbox"/> Humira [®] (Adalimumab) PFS <input type="checkbox"/> Humira [®] (Adalimumab) Pen <input type="checkbox"/> Humira [®] Psoriasis Starter Pack	<input type="checkbox"/> 40 mg SQ every other week <input type="checkbox"/> 40 mg SQ once a week <input type="checkbox"/> 80 mg SQ, followed by 40 mg every other week starting 1 week after initial dose <input type="checkbox"/> _____		____ kits	
<input type="checkbox"/> Remicade [®] (Infliximab)	<input type="checkbox"/> 5 mg/kg <input type="checkbox"/> _____ mg/kg (Please fill in weight section)	<input type="checkbox"/> IV at 0, 2 & 6 weeks (induction) <input type="checkbox"/> IV every 8 weeks <input type="checkbox"/> IV every _____ weeks	____ vials	
<input type="checkbox"/> Simponi [™] (Golimumab)	<input type="checkbox"/> 50 mg/0.5 ml single dose SmartJet AutoJet <input type="checkbox"/> 50 mg/0.5 ml single dose prefilled syringe	<input type="checkbox"/> Subcutaneously once monthly	____ doses	
<input type="checkbox"/> Stelara [™] (Ustekinumab) Single-use Prefilled Syringe	<input type="checkbox"/> 45 mg subcutaneously at week 0 and week 4 (≤ 220 pounds) <input type="checkbox"/> 90 mg subcutaneously at week 0 and week 4 (> 220 pounds) <input type="checkbox"/> 45 mg subcutaneously every 12 weeks (≤ 220 pounds) <input type="checkbox"/> 90 mg subcutaneously every 12 weeks (> 220 pounds)		____ doses	
Other: _____				

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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