Dermatology Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

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: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM
Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
Comorbidities: _____ Height: _____ Weight:_____ Date:_____
Allergies: _____ ☐ 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: ☐ L40.59 Psoriatic Arthritis ☐ L40.8 Psoriasis ☐ Other ICD 10 _____
Location: ☐ Scalp ☐ Groin ☐ Nails ☐ Others _____
Severity: ☐ Mild (<3%BSA) ☐ Moderate (3-10% BSA) ☐ Severe (>10% BSA)
PPD Test: ☐ Yes ☐ No Results: _____
Current/ Failed Therapies: _____

Prescription

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