Your Health, True Wealth

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:
f: 818-882-8929

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		
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 RNto 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 Northridge Pharmacy Specialty & Infusion's infusion protocol.
☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____