Dr. Ike's Pharmacy
ADVANCED SPECIALTY PHARMACY

DERMATOLOGY
REFERRAL FORM

Fax: **888.804.7717**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx**: ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alt. Phone: _____
Patient SS#: _____
DOB: _____ Gender: ❑ Male ❑ Female
Allergies: _____
Insurance: _____
ID#: _____ Phone: _____

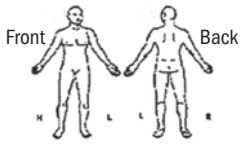
PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Diagnosis: **ICD-10 Code:** _____
❑ L40.0 Psoriasis ❑ L40.5 Psoriatic Arthritis Other: ❑ _____
• Date of Diagnosis: _____ OR Years With Disease _____

Medical Assessment (Within Last 12 Months):
• Psoriasis Severity: ❑ Moderate ❑ Moderate to Severe ❑ Severe
• Psoriasis Type: ❑ Plaque ❑ Other (please specify) _____

Patient Evaluation:
• Has patient been diagnosed with Lymphoma? ❑ Yes ❑ No
• Does patient have serious/active infection? ❑ Yes ❑ No
• Has TB test been performed? ❑ Yes ❑ No If yes, result: _____
Comments: _____

Patient Evaluation Cont
• _____ BSA
% affected by Psoriasis



• Has Hepatitis B been ruled out or treatment been iniated? ❑ Yes ❑ No
If NO, has treatment been initiated? ❑ Yes ❑ No
• Does patient have a latex allergy? ❑ Yes ❑ No
• Is patient's platelet count >52,000 cell/uL? ❑ Yes ❑ No
• Patient Weight: _____ kg/lbs ❑ Yes ❑ No

PRIOR (FAILED) MEDICATION:

	Medication	Reasons for Discontinuation
❑ Biologics/MTX:		
❑ PUVA/UVB:		
❑ Others:		

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY.	REFILLS
❑ **Otezla**	❑ Titration Pack or Date starter pack was provided ____ /____ / _____ ❑ 30 mg ❑ Bridge RX	❑ Take as instructed according to the package instructions presented for 28 days ❑ 1 tablet twice daily	#55 #60	
❑ **Cosentyx**	❑ 150 mg/mL Sensoready pen ❑ 150 mg/mL Pre-filled syringe ❑ 150 mg Lyophilized powder SDV	❑ Induction Dose: 300 mg subq at Weeks 0, 1, 2, 3, and 4 ❑ Maintenance Dose: 300 mg subq every 4 weeks		
❑ **Enbrel**	❑ 50 mg/ml Sureclick Autoinjector ❑ 50 mg/ml Prefilled Syringe ❑ 25 mg/0.5ml Prefilled Syringe ❑ 25 mg Vial	❑ Psoriasis Induction Dose: Inject 50mg SC TWICE a week (3-4 days apart) for 3 months, then maintenance dosing ❑ Maintenance Dose: Inject 50mg SC ONCE a week ❑ Other: _____		
❑ **Humira**	❑ Psoriasis Starter Package ❑ 40 mg/0.8ml Pen ❑ 40 mg/0.8ml Prefilled Syringe	❑ Psoriasis Induction Dose: Inject two 40mg pens/syringes SC on day 1, then one 40mg pen/syring on day 8, then one 40mg pen every other week ❑ Maintenance Dose: Inject one 40mg pen/syringe SC every other week ❑ Other: _____		
❑ **Stelara**	❑ 45 mg/ml Syringe ❑ 90 mg/ml Syringe	❑ For patients weighing <100kg (220lbs): inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks. ❑ For patients weighing>100kg (220lbs): Inject 90mg (two 45mg vials) SC initially and 4 weeks later, followed by 90mg every 12 weeks		

Primary ICD-10: _____ ❑ BRAF V600E ❑ BRAF V600K

❑ **Mekinist**	❑ 0.5 mg ❑ 1 mg ❑ 2 mg daily **Qty:** _____ ❑ Other _____ **Refill:** _____
❑ **Tafinlar**	❑ 50 mg ❑ 75 mg **Qty:** _____ **Refill:** _____ Take _____ capsules by mouth _____ time(s) a day
❑ **Zelboraf**	❑ 240 mg **Qty:** _____ **Refill:** _____ Take _____ capsules by mouth _____ time(s) a day

❑ **Erivedge** ❑ 150 mg Daily **Qty:** _____ **Refill:** _____
❑ Other _____

Has treatment started: ❑ Yes ❑ No Date: _____

Please complete the following appropriately:

Metastic basal cell carcinoma ❑ Yes ❑ No

OR

Locally advanced basal cell carcinoma recurred following surgery or not candidate for surgery ❑ Yes ❑ No

Previous Treatments:
❑ None ❑ Surgery ❑ Radiation ❑ Chemotherapy ❑ Other: _____

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____
Address: _____ License#: _____
City, State, Zip: _____ DEA#: _____
Phone: _____ Fax: _____ Contact Name: _____
Physician's Signature: _____ Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.