Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
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Dermatology Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location): _____ Date Needed: _____ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
- ❑ L40.0 Psoriasis vulgaris (including plaque psoriasis)
- ❑ L40.1 Generalized pustular psoriasis
- ❑ L40.4 Guttate Psoriasis ❑ L40.5 Psoriatic Arthritis
- ❑ L40.54 Juvenile psoriatic arthritis
- ❑ L73.2 Hidradenitis suppurativa
- ❑Other_____

Location of affected area(s): ❑Hands ❑Feet ❑Scalp ❑Groin ❑Nails ❑Other_____

Severity of condition: ❑Mild (up to 3% BSA) ❑Moderate (3-10% BSA) ❑Severe (>10% BSA) BSA affected _____%

Date of diagnosis (or years with disease)_____

TB/PPD test given? ❑Yes ❑No Date:_____ Results?_____

Prior and Current Treatment *(please attach list if necessary)*

Is the patient currently being treated or previously been treated for diagnosis indicated? ❑Yes ❑No

If yes, name the product(s), approximate date range(s) and response/outcome, listing current therapy first if applicable.

Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____

Does patient have any contraindications or intolerances to any medications? ❑Yes ❑No

If yes, please name medication and describe contraindication or reaction?_____

Will patient be discontinuing current medication(s) before starting new medication? ❑Yes ❑No

*Patient Authorization: I authorize my prescriber to share my information with this pharmacy as it relates to the prescription authorized and condition for which I am receiving authorized prescription. I further authorize this pharmacy to use the information provided by my prescriber to work with my insurance to determine eligibility and coverage for prescriptions.

Patient Signature_____Date:_____

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Cimzia®	❑ Starter Kit 200mg PFS ❑ 200mg/mL PFS	❑ Initial: 400mg SC at weeks 0, 2, & 4, then maintenance Maintenance: ❑ 200mg SC every other week OR ❑ 400mg SC every 4 weeks	1 Kit= 6 x 200mg/mL PFS 2 x 200mg/mL PFS	0 _____
Enbrel®	❑ 50mg/mL SureClick® Autoinjector ❑ 50mg/mL PFS	❑ Induction: 50mg SC twice weekly (72-96 hours apart) ❑ Maintenance: 50mg SC once weekly	8 x 50mg/mL doses 4 x 50mg/mL doses	_____ _____
Humira®	❑ Psoriasis Starter Kit ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	❑ Induction: 80mg SC Day 1, then 40mg on Day 8, then 40mg every OTHER week thereafter. ❑ Maintenance: 40mg SC every OTHER week	1 Kit=4 x 40mg/0.8mL Pens 2 x 40mg/0.8mL Pens	0 _____
	❑ Hidradenitis suppurativa Starter Kit ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	Induction: ❑ 160mg SC Day 1, then 80mg on Day 15 OR ❑ 80mg SC Day 1, 80mg SC Day 2, then 80mg on Day 15 Maintenance: ❑ 40mg SC every week starting Day 29 OR ❑ Other:_____	1 Kit=6 x 40/0.8mL Pens 4 X 40mg/0.8mL Pens 2 x 40mg/0.8mL Pens	0 _____
Otezla®	❑ Starter pack 28 day ❑ 30mg tablet	❑ Take as directed per package instructions ❑ 30mg PO twice daily ❑ _____	1 Starter Pack (55 tablets) 60 tablets _____	0 _____
Simponi®	❑ 50mg/0.5mL SmartJect® Autoinjector ❑ 50mg/0.5mL PFS	❑ Inject 50mg SC once monthly	1 x 50mg/0.5mL dose	_____
Stelara®	❑ ≤100kg Body Weight: 45mg/0.5mL PFS ❑ >100kg Body Weight: 90mg/1mL PFS	❑ Loading/induction: Inject 45mg SC at week 0 and week 4 ❑ Maintenance: Inject 45mg SC every 12 weeks ❑ Loading/induction: Inject 90mg SC at week 0 and week 4 ❑ Maintenance: Inject 90mg SC every 12 weeks	2 x 45mg/0.5mL PFS 1 x 45mg/0.5mL PFS 2 x 90mg/1mL PFS 1 x 90mg/1mL PFS	0 _____ 0 _____
Other	❑ _____	❑ _____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payors, processors and other entities.*

Prescriber's Signature: _____ Date:_____